WHAT IS PACE?

EXHIBIT 12
DATE 1/25/2011
HB

Program of All-Inclusive Care for the Elderly

A solution for elderly individuals wishing to stay in their homes

ELIGIBILITY REQUIREMENTS:

- 55 years old or older
- Residents of Yellowstone County
- Eligible to receive nursing home level of care
- Able to live safely at home with assistance

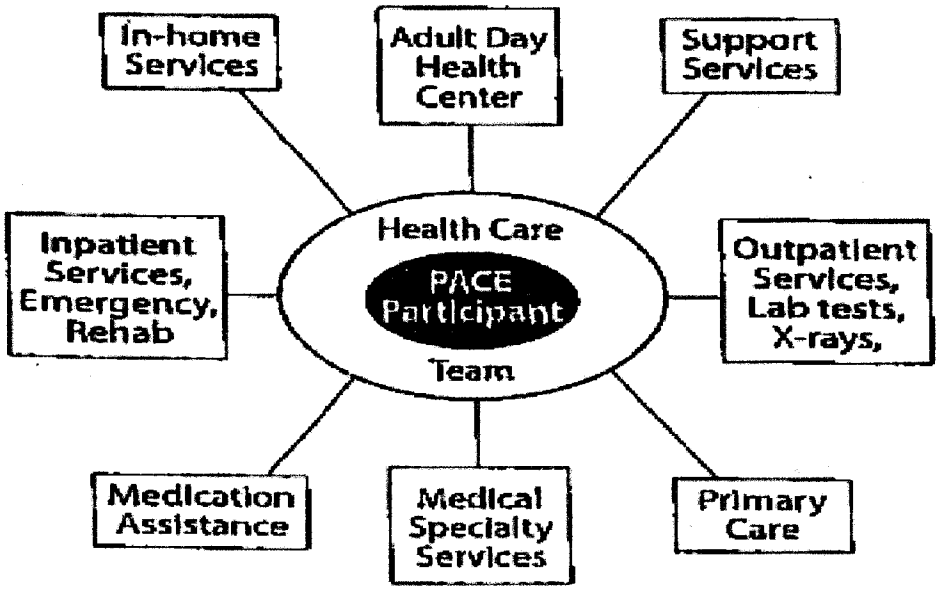
IDEAL PACE PATIENTS:

- Have difficulty managing medications
- Frequent calls to nurses
- Frequent visits to same day care or ER
- Limited social/family support
- Frequently cancel appointments or have transportation difficulties
- See multiple providers

FUNDING:

- Primarily funded by Medicare and Medicaid and now VA
- Those not eligible for Medicaid may still enroll if able to make a monthly payment

SERVICES:



THE FACE OF PACE

BR is a 73 year old Native American female who was referred to PACE by her mental health specialist in April of 2009. She was living alone in an apartment and was reluctant to accept help from community organizations. She is a very social lady and spent her afternoons riding the city buses for entertainment and company. Initially we had a very hard time establishing a connection with her, and she was not very accepting of our help either. Unfortunately, in January of 2010, she presented to the ER with abdominal pain and was found to have dead bowel. She needed to undergo an operation to remove the necrotic tissue which resulted in a permanent ileostomy. Because of her cognitive impairment she was unable to care for this appliance herself. After a few months in the nursing home, we were able to transfer her to a personal care home, providing her with a more home-like environment. This environment suits her better than the larger skilled nursing facility.

Since moving into the personal care home, she has thrived. Due to the intense nursing care through PACE we were able to find appropriate ileostomy appliances to protect her skin, and now she requires less frequent appliance changes. The staff at the personal care home takes excellent care of her, and she has formed friendships with other residents. She continues to come into the Day Center once a week. We now have a strong relationship with her and her brother. Both of them seem to trust PACE and are satisfied with her care.

TM is a 91 year old who was enrolled in PACE September 2010. At the time of enrollment, his family was considering nursing home admission as they were unable to find sufficient resources in town to provide enough care so that his daughter could continue to work. He is a frequent faller and just prior to enrollment he was hospitalized for injuries related to a fall. He has significant cognitive impairment and needs assistance with most of his activities of daily living.

At enrollment, we began bringing him in to the day center 5 days a week with a home health aide to help get him ready every morning, transports him to the center, and transports him home and stays with him until his daughter returns from work five days a week. His daughter is very appreciative of his care and feels that if it were not for PACE, her father would not be able to live out his life at home.

Billings Clinic

BILLINGS CLINIC PACE

PACE NEWS

WINTER 2010-2011

Medicare Part D & Medicare Advantage Plan Important Information

By Anne Gonzalez, Director

The "Fall Open Enrollment" or open enrollment period for Medicare drug plans (Part D) begins November 15, 2010 and extends through December 31, 2010. During this period, Medicare beneficiaries may join or change their Medicare Part D coverage. Of note, as a PACE participant, you may receive in-person, telephone or direct mail solicitations from Medicare Advantage and/or Part D Prescription Drug Plan (PDP) companies encouraging you to enroll in their programs.

The Fall Part D Open Enrollment DOES NOT apply to PACE participants! As a PACE participant, the Medicare Part D drug benefit is included with PACE your coverage. Unlike other Medicare Part D or Medicare Advantage plans, the PACE Part D benefit is fully funded so as a PACE participant, you never have to pay a deductible, co-payment, co-insurance or cost-share or pay for drugs out-of-pocket during a "donut hole" period.

If you are happy with your PACE coverage, it is important that you do not enroll or sign up for any other Part D or Medicare Advantage plan during this open enrollment period. If you do so, even without understanding what you are signing, you will be automatically disenrolled from PACE and will no longer be able to receive PACE services.

If you receive in-person, telephone or mail solicitations from Medicare Part D drug plans or Medicare Advantage companies and have questions about the solicitations or how these plans compare to PACE, please contact the PACE center at 406-247-6320 (Toll free 1-800-332-7156) for assistance. Our staff will be happy to assist you with any questions or concerns that you have.

Medicaid Recertification

Diann Spear, LCSW

Those of you who are receiving Medicaid benefits will receive a form to fill out every year. This form will come about one month before the anniversary of your Medicaid eligibility. The Office of Public Assistance requests that you fill out these forms. They review the information you provide on the forms to make certain you are still eligible to receive Medicaid benefits. They will also ask you to submit the most recent three months worth of bank statements.

It is extremely important that you complete the form and provide the bank statements as soon as you receive this request. If you do not do so, your Medicaid benefits will be stopped, and you will have no Medicaid benefits. In the event that this happens, you will have to reapply for Medicaid and, in the meantime, your PACE membership will be suspended.

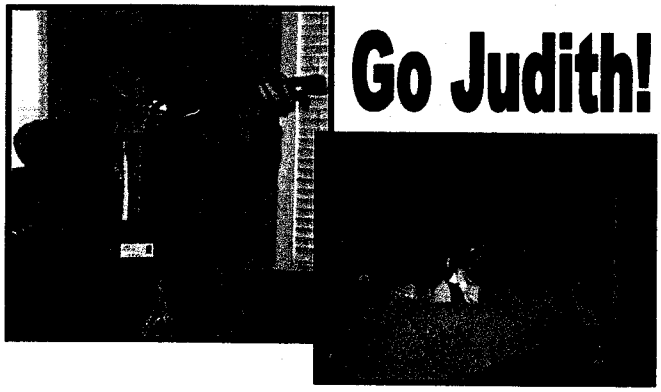
If you need assistance completing paperwork from Medicaid, please ask to see the PACE social worker who will assist you.

INSIDE THIS ISSUE:

Farewell 2010

Judith Bowman, RN, PACE Center Manager

The year 2011 has been a great success at PACE. The staff feels blessed to serve the 49 participants we currently have enrolled. Last year at this time our participants numbered 23. Although Anne Gonzalez, our director, will be leaving us the first part of 2011 to accept a job implementing new PACE sites across the United States, please be assured that all the staff at PACE remain committed to quality service to you and your loved ones. We look forward to serving you this coming year. We hope we have made a difference in your life or the life of someone you know.



Benefits & Coverage at PACE "Lock-In" Provision

by Stacy Wilson, LPN

The "lock-in" provision means that once you are a participant of Billings Clinic PACE, **all** your health care services must by provided through PACE. Services **must** be pre-approved by the Team and delivered by a PACE contracted provider. If you receive services from someone other than a PACE contracted provider, you may have to pay for them. If you receive services NOT authorized by the PACE Team, you may have to pay for them.

Emergency services are not includes in the "lock-in" provision.

There may be times that you need to see another doctor or specialist because of a medical or dental condition. **The PACE IDT (Team) must approve these services before PACE will pay for them.**

If you do see a provider that the PACE team has approved and the provider wants to refer to another doctor or for testing, please The contact the PACE center to get these requests approved. If they are not approved prior to your follow-up visit or test, you may have to pay for the visit or other expenses incurred.

Health for the New Year

By June Luptak, RD LN

Many of us enjoy a bowl of cereal in the morning or for an evening snack. And, why not, as it is easy and healthy choice. Fortified cereal provides vitamins, such as folate and the B vitamins and minerals, such as iron. Milk provides protein, B vitamins, and minerals such as calcium, phosphorus, and magnesium. And the fiber in cereals helps keep your digestive system working regularly. Read the Nutrition Facts label to find cereals and other foods that contain fiber. Look for choices with at least 3 grams (or more) of fiber per serving.

There are some easy, healthy, good tasting additions that can enhance a bowl of cereal. Try adding any or all of these ideas to give your cereal even more nutrients:

- Try adding nuts such as walnuts or almonds to either cold or cooked cereals
- Try adding flax seeds (usually available at health food store)

Try adding fruits – think of your favorites. They can be fresh (like bananas), frozen (such as blueberries, strawberries), canned such as peaches, even dried (like raisins or apples).

Fruited Oatmeal (can be eaten hot or cold)

Makes 6 servings

2 cups oats, uncooked

1 cup fruit juice (apple is best)

1 cup water

¾ cups diced, dried fruit or raisins

1 teaspoon maple syrup

½ teaspoon cinnamon

Dash of salt

Combine all ingredients; mix well. Cover and refrigerate overnight. Store tightly covered in refrigerator for up to 1 week. Stir well before eating hot or cold. NOTE: To heat, microwave ½ - ¾ cup on high for 1-2 minutes.

A Resolution For the New Year....Amazed & Amused

To love with an Amazed and Amused heart-
To think with an Amazed and Amused mind-
To live with an Amazed and Amused spirit-
This is my wish for you.

To see the joy and wonder amid the pain-
In a baby's first cry-
Or a love one's last breath.

To buy your ticket and take the ride-
To ride the rollercoaster with the wind in your hair-
To walk through the haunted house with your heart in your throat.

To delight in a child's giggle-
A perfect cup of coffee ~ your favorite song on the radio -
An unexpected windfall ~ a penny on the sidewalk (heads up, for good luck)-
A falling star ~ a good joke ~ a smile from a stranger.

To speed-up, slow-down, or go-backwards-
Whatever is required at the moment-
To keep yourself moving forward.

To grasp the game of life-
To play hard, win gracefully and lose honorably-
And get up to play again and again and again.

To embrace seeming negatives, trusting that they will turn out for the best-
To see the humor in life's absurdities-
To be able to laugh at yourself.

To have an attitude of gratitude and a forgiving spirit-
To cast off resentment and regret-
To practice acts of kindness ... random or otherwise.

To live each day Amazed and Amused—
This is to achieve true success.
This is to experience genuine happiness.

Karyn Buxman, RN, CPSE, CPAE

FAREWELL

Eleanor Sarver

February 1, 1926 to October 18, 2010

Come to me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for your souls. For my yoke is easy and my burden is light.

Matthew 11:25-30

Maintaining Quality of Life with Low Vision

Shara Bushman, OT

Low vision can cause difficulty in seeing detailed letters and numbers when reading, recognizing the slope of a curb, steps, or facial features, and distinguishing between similar colors, such as black and blue. Adults who have these problems may have trouble maintaining their independence and completing typical day-to-day activities.

It is possible for people with vision impairments to continue to live independent and meaningful lives. Healthcare practitioners can help people with low vision to continue living in their own homes and complete daily tasks, such as showering, dressing, cooking, grocery shopping, managing finances, and getting around in the community.

Occupational therapists and other healthcare providers can:

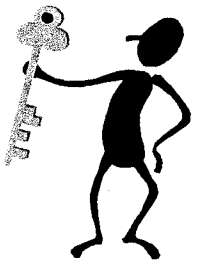
- Evaluate a person's environment at work and at home to determine how it can be altered to make the most out of a person's remaining vision.
- Help a person identify items used every day that need to "stand out" (provide a contrast) by marking them with bright colors so they can be easily found.
- Increase lighting so objects can be seen easily. In addition to providing extra light to items, occupational therapists also can identify areas that could be dangerous if not well lit, such as stairwells, kitchens, and spaces with area rugs.
- Reduce clutter in rooms to increase safety by removing items from countertops, tabletops, and floors.
- Educate a person on how to compensate for vision loss by using other senses, such as touch, hearing, and smell.
- Recommend and train a person to use assistive devices that can aid in completing daily activities, such as magnifiers, audio equipment, and voice-activated computers.

Continued on Page 7

Keeping Those Resolutions

Diann Spear, LCSW

One of the time honored traditions is New Year's resolutions. We reflect on the old year and make lists of things that we want to change in the New Year. For years I made the same resolutions – loose *lots* of weight and quit smoking. By March I always had to admit that I was not keeping either of my resolutions. I saw this inability to keep the resolutions as failure and a lack of character. Every time I failed, I lost some of the desire to try again.



New Year's Eve of 2008 I found myself making the same two resolutions but without much enthusiasm. The more I thought about my past inability to make those changes, the more unhappy I became with myself. Slowly it came to me that I set myself up for failure each year. I had chosen two extremely hard things to change, and I was expecting myself to accomplish them simultaneously. I would work hard on both of them and end up so cranky and unhappy that friends begged me to either consume a gallon of ice cream or smoke a pack of cigarettes. Either change in habit and lifestyle can be overwhelming. I decided to lower my expectations and tackle just one. On April 14, 2009 I quit smoking. Oh, I smoked right up until midnight of April 13th, but when I awoke on April 14th I did so without reaching for my "frenemy" the cigarette. I am proud to say that I have remained smoke free.

New Year's Eve of 2009 I proved to myself what a slow learner I can be. Again, I wasn't content to make just one resolution. No, I was flush from the success of quitting smoking. I made not two, but three resolutions. One of them to loose *lots* of weight. The other two equally as difficult. Obviously, I failed to follow through on any of the three. I keep forgetting what I know to be true: Make one major change at a time. Trying to change too much at once dooms me to failure.

This year I will choose one thing to change, and I will, hopefully, be able to celebrate success rather than moan about my lack of character and my failure to stay the course.


Day Center
Activities

Greetings From the Day Center

Kim Kolstad, Activities Coordinator

Hello and happy new year from activities and the day center

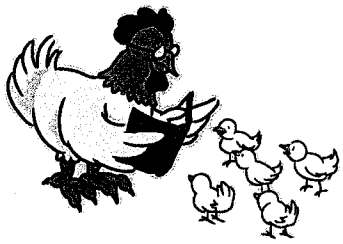
The holidays were a fun filled time at PACE. The day center elves were busy baking, singing, creating and decking the halls for Christmas.

Our December outing to the Moss mansion was a reminder of bygone holidays. Our participants delighted in the unique heirloom décor, the history of the moss family, and most of all enjoyed voting for their favorite Christmas tree.

Back at the day center we shared many memories of Christmas past and the joys of the world with the people we love most. With the New Year, we look forward to more adventures, new activities and the hope for spring and warmer weather.

Love and happy New Year,

Kim, Cleo, Anna, Mel and Jennifer



New Employee Introduction

Hi, My name is Jennifer Moody I am the new clinical nurse here at PACE. I am a mother of three children two girls and a boy ages 10, 9, 6. I am a Billings native and a fairly new nurse graduate from MSU, December 2008. My previous experience in the medical field includes working for Billings Clinic as a CNA in inpatient surgery then after graduation I moved on to work in a nursing home; Now here I am at PACE and enjoying it very much. I am an avid reader, and enjoy spending much of my free time with my children.

Baby It's Cold Outside!

Karen Gransbery, RN

Cold winter weather means one thing in Montana. Dry, dry, itchy skin. Add a little wind and you will find your skin drier yet.

So what can you do...besides leave Montana for the south and find the warm inviting skies of our dreams.

Moisturize your skin with one of the many lotions available. One of the best is Eucerin Crème that has a lanolin base. Lubriderm lotion is another lanolin based crème. All those wonderfully fragrant lotions and crèmes contain alcohol which gives the fine fragrance. However, be aware that alcohol is drying to the skin. Lanolin may leave you feeling greasy, and so use sparingly, but it soaks into the skin and the moisture lasts longer than the fragrant lotions.

An important thing to remember in the winter is frequent hand washing for prevention of illness, which dries the skin even quicker. So pour on the lotion!

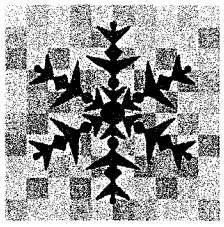
If hands get cracked from frequent hand washing you could be setting your self up for an infection. Any crack in the skin is a port for bacteria or a virus.

Good moisturizing lotions will prevent cracks in the skin.

Not only hands get dry in the winter. Feet and heels can get dry and cracked in the bitter cold weather. If you have diabetes, special attention needs to be paid to what your skin looks like. Do this by checking your feet daily. Look for reddened, dry cracked areas. If you are unable to check the bottoms of the feet, place a mirror on the floor and look at the bottoms noting any areas of concern. Then lather up the skin, especially the heels. Bed time is a good time to use crème on the feet. Slip on a pair of socks and jump into bed. Avoid putting lotion between the toes. There is usually enough moisture and additional lotion can cause athletes' foot which can be difficult to eradicate.

Keep hands clean and well moisturized. Stay healthy in this beautiful Montana winter!!

Montana



Facts on Foot Care
By Simmy Audet, RN

Caring for an often neglected part of your body - your feet - is important for everyone, but when you have diabetes, your feet need extra care and attention. Diabetes can damage the nerve endings and blood vessels in your feet which decreases sensation. So you are less likely to notice when an injury occurs. These injuries can easily develop into an infection especially in someone with diabetes. Prevention is the key to good foot care.

There are several simple key elements to keeping your feet healthy...

1. Inspect your feet daily. If you have difficulty seeing the bottoms of your feet, place a hand mirror on the floor and hold your foot above the mirror.
2. Wash your feet daily. Use soap sparingly as it dries your skin. Be sure and dry well between your toes.
3. Use lotion on your feet. Be sure your feet are dry before walking on them to prevent slipping. No lotion between toes.
4. Wear well-fitting socks and shoes at all times. Socks without seams are best. Shoes with a roomy toe box will prevent pressure on toes. Check your shoes often for any loose objects like pebbles or rough edges that may cause injury.
5. Do not use home remedies to treat foot problems. These can actually cause more harm than good.
6. Regular foot and nail care is important. Notify your nurse or provider early of any foot problems you are having.

Continued from Page 4....Maintaining Quality of Life with Low Vision

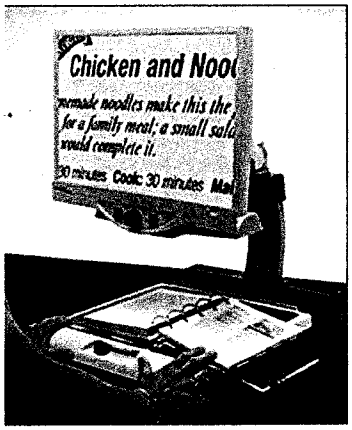
- Evaluate a person's ability to drive and determine whether a person with low vision can adjust his or her driving so that he or she can continue to get around safely or should develop alternative ways to get around.

What can friends and family of a person with low vision do?

- Stay educated about the person's vision ability.
- Help and support a person with low vision in adapting his or her home to keep it safe and functional.
- Help a person with low vision access community resources, including talking books, audio reader services, and centers for the blind.

Vision impairment is a serious issue that may affect many aspects of a person's life, including self cares, home management, and leisure activities. If you have further questions or concerns contact Billings Clinic PACE at 247-6320 or the Billings Clinic PACE Rehabilitation Department at 238-5987.

American Occupational Therapy Association, www.aota.org



PACE Referrals
By Anne Gonzalez, Director

Word of mouth is the best form of advertisement! If someone you know would benefit from PACE services, please consider making a referral to Billings Clinic PACE! Please obtain permission from the person that you are referring prior to making the referral. To make a referral in Billings call (406) 247-6320.

Do You Have a Complaint?

We at PACE believe that one of the most important rights a PACE participant or caregiver has is the right to complain about the delivery of any service as we are dedicated to providing the best service to each of you. The process for complaining is called "the grievance process." The complaint can be something as simple as "My hot lunch was served to me cold," or "My home health aide was rude to me." If you are dissatisfied about anything at PACE, we ask that you let us know. You may explain your complaint/grievance to any PACE team member or contractor who will then present the grievance to the team as a whole. A member of the team will investigate the complaint, and the team as a whole will resolve the matter. We pledge to respond to each complaint within 72 hours. The initial response may be verbal, but you will also receive a written response from our PACE Center Manager, Judith Bowman. If you have questions about the PACE grievance process, contact Diann Spear, PACE Social worker at 247-6320.

Billings PACE Staff

Office/Day Center Staff

Anne Gonzalez	PACE Director
Judith Bowman	Manager, RN
Stacy Wilson	Clinical Coordinator, LPN
Jennifer Moody	Clinic Nurse,
Simmy Audet	Quality Coordinator, RN
Karen Gransberry	Home Care Coordinator, RN
Diann Spear	Social Worker, LCSW
Carole Bleeker	Technical Assistant
Mel Gregg	Transportation Coordinator, MA/CNA
Anna Deonier	Day Center, CNA
Jennifer Rohrer	Day Center, CNA
Cleo Shea	Day Center, CNA
Kimberly Kolstad	Activities Coordinator
Shara Bushman	Occupational Therapist
Amanda Langve	Physical Therapist
Willee Brese	Dietician

Physicians/Nurse Practitioners

Patricia Coon, MD	Medical Director/Geriatrician
Larry Severa, MD	Family Practice
Virginia Mohl, MD	Family Practice
Irene Lohkamp, MD	Internal Medicine
Miranda Meunier, GNP. BC	Nurse Practitioner

Billings Clinic

Billings Clinic PACE

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Billings, MT 59107-7000

Phone: 406-247-6320
Fax: 406-247-6218
E-mail: dspear@billingsclinic.org

PACE
Program of All Inclusive Care
for the Elderly

We're on the Web
http://www.billingsclinic.com/body.cfm?id=778

What is PACE?

Program of All-Inclusive Care for the Elderly. It is a comprehensive, multidisciplinary approach to providing health and social cares to elderly individuals with the goal of keeping them in their homes. The program includes a variety of services, as displayed on the handout, including in-home care, day center services, transportation, medication management, and primary care services. These services are provided by an interdisciplinary team who are all centered around the participant. The eligibility requirements for the program include 55 years of age, a resident of Yellowstone county, eligible to receive nursing home level of care (needs assistance with ADLs,) and able to live safely at home with assistance.

The program is funded through a three way agreement between Medicare, Medicaid, and the organization (Billings Clinic). We receive fixed payments from both Medicare and Medicaid to cover all medical and related expenses (medications, home health, equipment, etc) that the PACE team determines the participant needs.

PACE is a national program that developed in the early '70s in San Francisco. Currently there are 75 programs operating in 29 states. PACE was founded on the philosophy that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. The family member is an integral member of the team, and with the assistance of PACE, they can be free of the burden of being a caregiver and instead can be a daughter, son, husband, wife, etc. By avoiding what we in the medical field call "caregiver burnout", caregivers are able to remain longer in the workforce, benefiting the Montana economy and hopefully prolonging the need for nursing home admission. In fact, in an article in the March 2010 Journal of Gerontology, PACE outcomes, including nursing home admission, death, and overall health status, were substantially better when compared to waiver programs or long term care facilities.

My Standpoint

I am a native Montanan. I graduated from Great Falls High School in 1998 and the second I left home for college in Minnesota, I left Montana in my rearview mirror and did not plan to look back. I spent 10 years outside of Montana living in Minneapolis, Seattle, and North Carolina all while advancing my nursing career. I received my Masters in Nursing from Duke University in 2008 after completing a Gerontological Nurse Practitioner program specializing in the care of older adults. During my tenure at Duke, I became interested in health care public policy and took courses on innovative health care models including the PACE model. I realized how vital such programs were to not only maintain the health of seniors but also ease the financial burden the "baby boomer" generation would be placing on federal and state governments. In studying PACE, I appreciated the importance of the proven outcomes they produce including reduction in hospitalizations and permanent placements at nursing homes. The model honors what most seniors want and goals that I set for my patients: to stay in familiar surroundings, to maintain their sense of autonomy, and to maintain a maximum level of physical, social, and cognitive function.

When I graduated from Duke, I wanted to bring what I had learned home to Montana. Serendipitously, I came across a posting for a nurse practitioner position in the geriatric department at Billings Clinic and discovered that much of my time would be spent being a provider for a PACE program that was under development. Of course I jumped at the chance to be part of something I felt so passionate about and I knew would improve the lives of elders and their families in Billings. PACE is a substantial reason I came back to the state.

The Face of PACE (refer to handout)

BR has been with the program now for nearly two years. When we first met her, she was living alone and was reluctant to receive help from community organizations. She is Native American and initially we had a difficult time breaking through the cultural barriers. Unfortunately, about a year ago, she developed a bowel obstruction which required surgical intervention and placement of an ileostomy – a device to collect her stool. Because of her cognitive impairment, she was unable to manage this device herself and needed 24 hour care. We were able to limit her nursing home stay to 2 months and place her in a personal care home. The staff there that excellent care of her and she has formed friendships with the other residents. She continues to come into the day center once a week and we now have a strong, trusting relationship with her and her brother.

TM is one of our veterans. He enrolled in the program in September at the spry age of 91. At the time of enrollment, his family was considering nursing home placement as they were unable to find sufficient resources in town to provide adequate care so that his daughter could continue to work. He falls frequently and has significant dementia so he cannot be left alone and need assistance in most daily tasks. After joining the PACE program, he began coming to the day center 5 days a week with a home health aide going to get him ready every morning, transports him to the day center, and then picks him up and stays with him until his daughter returns home from work. His daughter is very appreciative of the care he receives and feels that if it were not for PACE, her father would not be able to live out the rest of his life at home.

Why is PACE Needed in Montana?

If PACE were to close, BR would need a waiver slot and if one was not immediately available, she would need to be placed in a nursing home due to her care needs. TM would need nursing home placement. These are just two of our participants. Should PACE close, approximately 20% of our population would need to be immediately placed in an institution and several others would require waiver slots. Because all of our participants are determined to be nursing home eligible prior to enrollment in PACE, all of our participants are at high risk for nursing home admission without the aggressive medical and home care services they currently receive through PACE. As a provider, PACE is assuming the risk of caring for these frail individuals. By closing PACE's doors in an effort to save money, the state assumes the risk and may actually be spending more in nursing home costs down the road as well as losing the $1.5 million in federal dollars that help fray the cost of caring for these seniors.

I believe, just like with children, it takes a village to care for an elder. Here in Montana, our villages need to be more adept at this as, by the year 2025, over 25% of the population in all Montana counties will be over the age of 65 (and still voting!) Because of the way PACE is organized and the philosophy it supports, we have formed important community partnerships. By eliminating PACE, PACE will loose not only the 12 FTE associated directly with the PACE program at a cost of $713,000 in salaries, but will no longer be able to support the other community organization and business in Billings currently servicing PACE participants such as the Met bus system and numerous home health agencies.

As a provider, I believe in and strive to continue the high quality and cost-efficient care we have demonstrated in caring for complicated, vulnerable, and historically expensive frail elderly. It is the way health care should be provided for this population. The individualized, patient centered approach with a goal of remaining at home is what sets PACE apart from every other long term care option. PACE is the only program in the nation that aligns the financial incentives of the provider with the member's desire to live as healthy as possible in the home. By continuing it's commitment to PACE, Montana can become a more forward thinking state who believes in the importance of a proactive response to the needs of its elderly population.

I recently saw a picture that I should have included in your packet but decided against. It was a picture of a pile of cow dung with little grass spouts growing from it. It reminded me our current fragmented health care system and the glimmer of hope that PACE provides for young health professionals like me. PACE really is the gold standard of community based programs and I think older Montanans desire the best.

Good Morning,

Members of the Joint Appropriations Committee on Health and Human Services: My name is Clark Swan, from Billings. I am extremely grateful for the opportunity to speak to you today.

Thank you for serving in the Montana Legislature. I know you give up your time with family and friends for public service and we appreciate it.

I would like to briefly tell you what the PACE Program has meant to my wife, Sharon Swan. Seven years ago, Sharon was diagnosed w/ Lewy Bodies Dementia and Alzheimers dementia. She will be 62 years old next month. I lost my job with a company I worked for for 18 years, because I could no longer travel. I became her primary caregiver as I no longer felt comfortable leaving her home alone. Three years ago I became

aware of the PACE Program in Billings. Sharon became the 4th participant that year. There are now appox. 50 folks in Pace.

Pace provides in-home care, twice a day, five days a week. Her gals would come into our home and get her ready for the day where she was involved in activities at the PACE Center. Being a very social individual, Sharon thrived in the Day Center environment. She was able to make new friends and quickly won over the hearts of the Day Center staff. I was able to return to work parttime and many of my care-giving tasks were relieved so I was able to focus on being a husband when I was with my wife, Sharon, instead as a caregiver.

Sharon's dementia has continued to progress. On October 22, last fall, I made the decision that I have been dreading for

almost seven years. Realizing that her care was more than I could handle, we let her go into a personal care home. PACE's relationship with this private residence was instrumental in her transition into her new caregiving experience. The intimate social environment of the personal care home is well suited for her personality. She continues to come into the PACE Center several days a week. I am deeply grateful for the care she has received through the PACE program. I feel that without the PACE program, she would have been placed in a nursing home long ago.

This program has been a Godsend and a lifesaver, in more ways than we can ever imagine.

The Pace Program is a SYMBOL of HOPE and a viable, tangible option for families that are desperately seeking answers

for the long-term care of their loved ones.

Please, Please do not let the PACE Program fall by the wayside. It can help many more families in the future, just as it has helped my wife and me.

A short anecdote, to illustrate her progression,-- she has attached herself to a resident in her personal care home, a gentleman in a wheelchair and on oxygen—she thinks he is me! The progression of dementia has been described as going to the same funeral over and over again. We do not wait for the final funeral to grieve, grieving started 7 years ago.

Thank you for supporting PACE and thank you for serving the residents of the great state of Montana. God Bless All.

Billings Clinic

PACE Center
3155 Avenue C
Billings, Montana 59102

January 24, 2011

The Honorable Don Roberts, Chairman
Joint Appropriations Committee on Health and Human Services
Montana House of Representatives

Re: PACE Funding

Dear Chairman Roberts and Committee Members:

As the Nurse Practioner of the Program of All Inclusive Care for the Elderly (PACE) in Billings, I write to urge the continued funding support for this program by the State of Montana.

Geriatrics has been my specialty for over 10 years in nursing practice and I graduated from a specialized geriatric program during my Master's training, obtaining Gerontological Nurse Practitioner certification from Duke University. During my nursing career, I have seen the struggle and sacrifice of elderly patients and their families struggling to remain at home in spite of tremendous medical, financial and social barriers.

At PACE I have seen these barriers melt away.

Our sickest and most vulnerable elders receive a high standard of intensive medical care as well as the home services needed for improved quality of life while maintaining independence in the home setting. The program supports caregivers in a concrete way making the care in the home more viable.

The PACE program has demonstrated success in providing evidence-based models of care while simultaneously decreasing hospital admission and readmission rates. PACE has operated in the "Black" without sacrificing quality patient care and services. There are several new models of care being sponsored, but PACE developed in the 70's and has a proven track record. The program is innovative and a step forward for Montana seniors.

Restore the funding for PACE. It is the future of Geriatric patient care. It is our future.

Sincerely,

M. Meunier GNP

Miranda Meunier, GNP
Billings Clinic PACE

Billings Clinic

PACE Center
3155 Avenue C
Billings, Montana 59102

January 7, 2011

Dear Member of the Joint Appropriations Committee on Health and Human Services:

I am writing to you as a caregiver of people who participate in PACE. I know you are grappling with many tough public health funding issues and I appreciate your public service.

I have work as a registered nurse with the Billings Clinic PACE program for more than a year. PACE programs function as a fully accountable care organization. They are responsible for the quality and cost of **ALL** care provided both directly and through contracted providers. Monthly capitated payments from Medicare and Medicaid are pooled and care is provided following a comprehensive assessment of the participant's needs. PACE's inclusive capitated single payment for all necessary care provides strong incentives to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and nursing home care. As you know coordinated care is shown to decrease admissions and ER visits as well as hospitalization days. The care of PACE participants goes beyond case management in facilitating early treatment of medical conditions, eliminating polypharmacy and providing in-home care so participants remain in their own homes for as long as possible. And if placement is necessary, that it is the least restrictive for the participant. Beyond being fiscally responsible, **PACE is the right thing to do**.

Billings Clinic approached the state DPHHS in 2007 and encouraged them to offer this managed care option to the dual-eligible population in our state. After much investment, time and money, and learning how to deliver health care to a complex, high cost population on a fixed budget, we are faced with our Medicaid funding being eliminated, should the Governor's budget be enacted by the Legislature. The program will be forced to close. Billings Clinic believes this will be a short-sighted decision.

I have directly seen the positive personal impact of this program. The PACE program changes the lives of our participants and their caregivers on a daily basis. But I also believe there are financial benefits to this program as well. Please support PACE.

Sincerely,

Jimmy Audetrew

PACE Staff - General

January 19, 2011

Dear Member of the Joint Appropriations Committee on Health and Human Services:

Thank you for your public service and taking the time to read my letter. I have been a geriatric nurse for 16 years. I am proud to say that I have been with the PACE program since the day it opened on October 1, 2008.

PACE is about people getting the medical care they deserve and so much more. We focus not only on coordinating their current medical conditions, but strongly in preventative care. In geriatric medicine we often find other contributing factors that lead to their medical problems. At PACE we have a comprehensive team approach to look at the entire person. This team consists of an MD, NP, RNs. LPNs, CNAs, PT, OT, Dieticians, Activities Coordinator, Transportation, Social Worker, Home Care, Family Members and most important, the Participant.

As I look back over the last two years of PACE, I think of all the people who have been helped by this program. I would like to share a few examples with you. For confidentiality reasons, I have changed their names.

Frank is a man that was pan handling with his walker to get extra money. The PACE Social Worker assisted him with getting a payee to help with his finances so he no longer has to ask people for money on a street corner in the cold.

Sally was a 60 year old that came to us, barely able to stand. She did not have long to live due to her liver disease. With PACE medical coordination her life span was extended and the quality of her life had greatly improved.

Isabel comes to our day center 5 days per week for socialization and medical monitoring. Isabel said, "I like to come to PACE, because people care about me here".

Patricia had a stroke 40 years ago and is in a wheel chair. She is a Hurricane Katrina survivor. She moved to Montana for a better life. She lives with her daughter in poor housing conditions in Billings. PACE built her a ramp so she can safely leave her home. She enjoys coming to the PACE Day Center for her medical care and socialization.

Please consider these people and the many others that we can help as you make your decision. These people need us. Thank you!

Sincerely,

Anastasia M. Wilson

Anastasia M. Wilson

January 21, 2011

Dear Health and Human Services Committee Vice Chair Sen Dave Lewis:

Thank you for being a public servant at the Montana Legislature. I especially appreciate you considering the challenging issues of public health on this committee.

I am the daughter of Jack and Shirley, 85 and 88 year old World War II veterans. Being proud and self-reliant, it has only been within the last year that have I gotten permission from them to check into potential Veterans Administration (VA) benefits. After recovering from a brain abscess and surgeries for prostate cancer, a kidney nodule, and cataracts, within the past year and a half Jack has had the diagnoses of diabetes, COPD, and dementia added to his hypertensive and hearing impairment history. Shirley has had surgeries for double knee replacement and a hand problem due to arthritis, osteoporosis, hypercholesterolemia, and hypertension, but more importantly her Alzheimer's dementia has gotten progressively worse during the last year. They want very much to remain in their home, but find it increasingly difficult without financial oversight, medication management, appointment coordination, cooking, housekeeping, shopping, and personal hygiene help from my brother and me and five day a week Senior Day Care services. Both of their physicians agree with family members that they would benefit greatly from the PACE program for what remaining time they have.

I have been very impressed with what I have learned about the 40 year history of PACE programs across the US. There are both medical and economic benefits for supporting seniors who wish to remain in their familiar home environment, which are noted in an article by Boult and Wieland in the November 3, 2010 issue of the Journal of the American Medical Association (JAMA). In July of 2010 I attended a monthly caregiver's meeting and heard that Billings was chosen to be a location for VA financial support for veteran participation in the PACE program. This was an acknowledgement of the quality of and need for the Billings PACE program, which was affirmed by the extremely positive audit results of the Montana Centers for Medicare and Medicaid Services (CMS) team on September 10, 2010. I have worked tirelessly for the chance for my parents to receive PACE benefits through the VA. My mother had two Emergency Room visits over the recent holidays, so I was very appreciative that the VA and PACE employees worked diligently to consider PACE participation by my parents starting February 1. Now that they are on the threshold of assistance I am distraught to hear that program funding is on the list of potential state budget cuts. I pray that you vote for the continuance of $315,000 in budget support of a program that brings an additional $1.4 million in federal support to an area with one of the highest percentages of veterans and an increasing population of older citizens. (As of July 1, 2010 there were 2647 veterans 55 years and older living in Yellowstone county – Billings according to the US Department of Veterans Affairs). As a 25-year state employee, who has experienced many budget cuts, voting against this budget cut is the type of matching funds/partner program efficiency that I want as a tax paying citizen. It is my understanding that this important program is also supported by Senators Baucus and Tester. Many other non cost-sharing cuts should be considered before cutting funding for this program.

Sincerely,

Kathleen M. Burke

Kathleen M. Burke
1590 Babcock Blvd.
Billings, MT 59105-1673

January 23, 2011

Dear Member of the Joint Appropriations Committee on Health and Human Services:

Thank you for serving our beautiful state of Montana through the Legislature. I appreciate the generous gift of time and service that you give to our state and to its citizens.

I would like to tell you how the PACE program has helped my family and in particular my 91 year old father, Ted Matzen, a World War II veteran who had lived independently until he had a stroke in July, 2009. Following his hospitalization and rehabilitation, dad came to live with my husband and me in October of that year. My brother, who has a disability, stayed with dad during the day, 5 days a week while my husband and I were at work. This arrangement worked well for us for almost a year, until my brother was no longer able to provide dad's care during the day. In September, 2010, PACE stepped in and provided the coverage that permitted my husband and I to continue our employment. In home care is provided twice a day, 5 days a week; in the morning to assist with his ADLs and for transportation to the Day Center and to bring dad home in the afternoon and stay with him until I arrive home from work at 5:00 PM. Medicare and the VA provide the funding for dad's participation.

Our experience with the Pace Program has been 100% successful. Dad is much better off, physically and emotionally, as a result of his enrollment and participation in this remarkable program than he was prior to their involvement. Dad received a comprehensive evaluation by a PACE physician and specific adjustments to his medications. He was provided with a roho cushion that travels back and forth with him and that, in conjunction with the new skin care protocol implemented by PACE, has significantly improved and maintained intact his skin. Dad had a significant fall shortly before he enrolled in PACE that required hospitalization and could easily have been life threatening. On occasion dad forgets to call us to assist him to the bathroom at night and was at risk for another fall. PACE provided a bed alarm that has alerted us that he was up on multiple occasions and enabled us to provide the assistance that he needs.

The most important aspect of our involvement in the PACE Program, in my opinion, is the happiness that it has brought to my father. Unfortunately, for me and my husband, the stroke has not left dad with the ability to understand the status of his health or the level of care that he requires. He believes that he is capable of returning to his home and living alone. It is his heart's desire to do this and in his confusion he believes that the reason he cannot is because I and my husband are preventing it. I have tried many times, unsuccessfully, to help him understand the truth of his situation. As a result of this belief, he is not very happy when he is at home with us. Our consolation is that he is quite happy when he is at PACE. He loves to joke and to make people laugh and has established warm and caring relationships with the people at PACE. It is not possible to put into words the gratitude we feel toward the extraordinary staff of the PACE Program that have facilitated the return of the father that I love and remember, and provided the venue that nurtures and supports all aspects of his human condition.

We ask that you continue to provide the funding necessary to support this valuable program that has proven its efficacy in providing care for the elderly of our community. Without this funding PACE will cease to be available and as a result my father will be placed in a nursing home. He does have the reasoning necessary to understand this and has adamantly pleaded not to be placed there. Please support PACE and the elderly citizens of our community.

Respectfully,

Connie and Tom McDonald
5131 Cherokee Trail
Billings, MT 59106

> Dear Representative Roberts,
> I would like to encourage your support for the PACE program in Montanna.
> I am writing with my cousin and his wife, Clark and Sharon Swan in Billings. They have roots that go back for generations in Montanna. Any city would truly desire to have them as members of their community.
> After raising their family, Sharon developed Alzheimers disease. It is devastating to see the toll this insidious degenerative disease takes. Clark has dealt with this with courage and faith as he told me how much the PACE program has helped him with the changes. This resource has strengthened their family and community in a very cost effective manner. There are so many aspects for this type of care that one cannot hope to navigate all of them.
> I feel this is part of a larger community effort. I have seen how effective a similar program to PACE has been in the metro Denver, CO area as my brother and his wife have had to deal with his mother-in-law with this same disease. We are part of a larger community in our country and this program strenthens our community in that it helps to coordinate a myriad of skilled professionals to help families deal with difficulties such as Alzheimers.
>
> Thank you.
>
> Paul Reinhart
>
>
>

Billings Clinic

January 21, 2011

The Honorable Don Roberts, Chairman
Joint Appropriations Committee on Health and Human Services
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

RE: PACE Program Support

Dear Chairman Roberts and Members of the Joint Appropriations Committee on Health and Human Services:

I want to thank you and the committee members for your service to the people of Montana by serving on the Joint Appropriations Committee on Health and Human Services. I am writing in support of Billings Clinic's efforts to seek the committee's consideration of reinstating the $314,459 in the Senior and Long Term Care's budget, NP 55423, and avoid elimination of the PACE program (Program for the All-Inclusive Care for the Elderly).

The objective of PACE organizations is to enable older adults certified by their states as eligible for nursing home level of care to remain at home and in their communities as an alternative to long-term institutional placement. This objective is accomplished by PACE interdisciplinary teams that work together with program participants and their families to develop and implement individualized, comprehensive, and fully integrated care plans that address the full spectrum of program participants' health and long-term care needs. PACE originated as a Congressionally-authorized demonstration program and, in 1997, was established as a permanent Medicare provider and a voluntary state option under Medicaid.

PACE is funded by combined Medicare and Medicaid capitated (fixed) payments. PACE providers assume **full financial risk** for providing the **entire** range of healthcare and support services needed by PACE participants including preventative, primary, specialty, acute and even long term care. PACE has proven to be a successful model for states who are struggling with the escalating cost of caring for a high risk, frail, Medicaid eligible elderly population in a cost effective manner. In fact, many states have mandated expanding PACE programs as way of minimizing exposure to increasing Medicaid health care costs and creating a way to accurately predict and budget for the cost of caring for this ever increasing population.

Since opening in 2008, Billings Clinic PACE has served over 80 participants. As of January 2010 Billings Clinic PACE serves 52 participants locally and we expect over the next year to grow to 70 participants. As part of the rural PACE demonstration grant we operated a rural spoke PACE program in Livingston until December 2010. Achieving adequate enrollment was a challenge in the rural site, in part

due to the strict eligibility requirement of Medicaid in Montana. The Billings site has continued to grow and has proven to be sustainable.

This year, Billings Clinic PACE was selected as one of seven PACE programs in the nation to partner with the Veteran's Administration to provide PACE services to eligible Veterans. Veteran participants must meet the same eligibility criteria as all PACE participants and the VA pays PACE a capitated payment for services in place of the traditional Medicaid payment. Because Montana has extremely limited community based services to meet the needs of frail elderly Veterans, PACE has provided a welcome alternative to nursing home placement. Since July, Billings Clinic PACE has served over 25 Veterans and is the largest provider of PACE services to Veterans in the nation. The Montana VA Healthcare System has plans to enroll 45 additional Veterans in the Billings Clinic PACE program over the next year. In addition to community based support and primary medical services, PACE Veterans also receive specialty care, eye care and dental care that they are not otherwise entitled to under their VA medical coverage. Care and services are provided in the Veteran's home community relieving them of the burden of traveling or being placed hours away from their home and families. Veteran and caregiver satisfaction with the PACE program has been overwhelmingly positive and the program is highly regarded by VA Medical staff. Because PACE operates under a 3-way contractual arrangement between Billings Clinic, the state (DPHHS) and the federal government (CMS), if PACE funding is eliminated, it not only eliminates this program for Medicare and Medicaid eligible individuals, but it also will eliminate the program for Veterans.

If the Billings Clinic PACE program is eliminated, current participants will likely be transferred to nursing homes (all PACE participants have been certified as nursing home eligible). The average nursing home daily rate is twice the daily cost of the PACE program to the state. In a time where Medicaid is trying to reduce health care costs, elimination of this cost effective program would appear short-sighted.

Thank you for your consideration of this important matter.

Sincerely,

Anne Gonzalez

Anne Gonzalez
Director
Billings Clinic PACE
3155 Avenue C
Billings, MT 59102
(406) 794-5981

cc: Senator Dave Lewis, Vice Chair

Billings Clinic

January 24, 2011

PACE Center
3155 Avenue C
Billings, Montana 59102

The Honorable Don Roberts, Chairman
Joint Appropriations Committee on Health and Human Services
Montana House of Representatives

Re: PACE Funding

Dear Chairman Roberts and Committee Members:

As the Medical Director of the Program of All Inclusive Care for the Elderly (PACE) in Billings, I write to urge the continued funding support for this program by the State of Montana.

Family Medicine has been my specialty for over 20 years before I attended the Geriatric Fellowship Program at Brody School of Medicine. During those 20 years I have seen the struggle and sacrifice of patients and their families. I have seen the caregivers as they attempt to help keep their elders at home in spite of tremendous medical, financial and social barriers.

At PACE I have seen these barriers melt away.

Our sickest and most vulnerable elders receive a high standard of intensive medical care as well as the home services needed for improved quality of life. The program supports caregivers in a concrete way making the care in the home more viable.

The multidisciplinary team meets every morning to discuss all the participants who had any difficulties over the past 24 hours. After that, the team meets to review the needs of all participants coming to PACE that day. The rest of the day is spent in patient care by practitioners, nurses, social workers and physical, occupational and recreational therapists. Through family conferences and many hands-on encounters we work to ensure the safety and health of the participants and to bolster the coping skills of caregivers.

The PACE program has demonstrated success in providing evidence-based models of care while simultaneously decreasing hospital admission and readmission rates. PACE has operated in the "Black" without sacrificing quality patient care and services.

Restore the funding for PACE. It is the future of Geriatric patient care. It is our future.

Sincerely,

Irene Lohkamp MD
Geriatrics, Billings Clinic PACE

The Washington Post

Federal program aims to keep seniors out of hospitals and nursing homes

By Susan Jaffe
Kaiser Health News
Monday, December 20, 2010; 7:02 PM

Several mornings a week, a white van stops at Geraldine Miller's house just east of Baltimore to pick her up for ElderPlus, a government-subsidized day-care program for adults on the campus of the Johns Hopkins Bayview Medical Center.

Because Miller, who is 75 and uses a walker, has trouble getting down the stairs from her second-floor apartment, the driver comes inside to help. When she feels wobbly, he lends her an arm. When she feels strong, he faces her and steps down backward on the steps so he can catch her if she falls. When it rains, he shelters her with an umbrella. This is the sort of extra care that makes ElderPlus different.

ElderPlus is part of PACE, the Program for All-Inclusive Care for Elderly, which provides comprehensive medical and social services to frail, low-income seniors with serious health problems.

More than 23,000 people are enrolled at 166 sites in 29 states, according to the National PACE Association, a trade group. There are no PACE sites in the Washington area now, but Inova Health System plans to open a Northern Virginia location next fall, and seniors' advocates are working to bring a PACE site to the District.

PACE, first authorized by Congress in the 1980s as a pilot project, is intended to help seniors stay in their homes as long as possible. If done effectively, supporters say, the program can reduce costly hospital and nursing home stays. And keeping seniors healthy can save money for Medicare, the federal program for the elderly, and Medicaid, the state-federal program for the poor and disabled.

Seniors like the program because it "honors what the elderly want, which is to stay in their familiar surroundings, to be autonomous," says Terry Smith, director of long-term care at the Virginia Department of Medical Assistance Services, which operates the state's Medicaid program.

http://www.washingtonpost.com/wp-dyn/content/article/2010/12/20/AR2010122004717_pf.html

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The Washington Post

Federal program aims to keep seniors out of hospitals and nursing homes

Miller, the ElderPlus enrollee, says her friends and staff in the program are "like a family." The medical team there spotted her kidney cancer early and treated it successfully. "It's just like you are at home, and if you have a problem, you always have someone you can go to."

Under an innovative financing arrangement, PACE sponsors - for example, Johns Hopkins - get a set monthly amount from the state and federal government to provide seniors with all the medical and other services they need, not just what is covered under traditional Medicaid and Medicare.

For ElderPlus, the payment is an average of $5,600 per person a month shared about equally by Medicaid and Medicare. In return, ElderPlus, which can serve up to 150 people and has been in operation for 14 years, is responsible for every aspect of participants' medical treatment, including nursing home care and hospitalizations.

ElderPlus operates a clinic, a pharmacy, an adult day-care center, a dining hall and a fleet of eight vans to ferry participants to and from home. Hospital care is provided by Johns Hopkins.

Seniors are served breakfast and lunch in a spacious, L-shaped dining room adjacent to a patio where some grow tomatoes and flowers. Down the hall are a physician, nurse practitioner, social worker, pharmacist and physical therapist, available for regular appointments.

A dentist, an optometrist, an optician, a psychiatrist and a podiatrist visit several times a month. A part-time dietitian tries to persuade participants it's never too late to improve their eating habits and has made a few converts. Participants can get physical or occupational therapy beyond the normal Medicare limits, as well as dentures, eyeglasses and hearing aids - items that aren't covered by traditional Medicare - at no cost.

The extra care extends to home when needed, usually on a temporary basis.

Doctors or nurse practitioners make home visits, and home health aides may help with light housekeeping and other chores. When

Federal program aims to keep seniors out of hospitals and nursing homes

home inspections have found safety hazards, ElderPlus has installed staircase railings, handheld showers and wheelchair ramps. It also has bought home air conditioners for people with breathing problems.

One of PACE's biggest boosters is Donald Berwick, a physician who heads the federal Centers for Medicare and Medicaid Services, or CMS, which oversees the PACE sites.

"I think expansion of PACE is a great idea, and even more important is building PACE principles," he says, adding that its multidisciplinary approach, unified funding stream and other pioneering techniques could help many chronically ill people.

To be eligible for PACE, people must be at least 55 years old and qualify for Medicaid, Medicare or, in most cases, both. They must meet their state's Medicaid criteria for requiring nursing home care, live within the PACE service area and be able to live safely at home with PACE assistance. Since PACE is a managed-care plan, the enrollees must agree to get their medical care only through PACE providers. These requirements may partially explain while the program is still relatively small.

PACE participants are among the most complicated geriatric patients and often suffer from several concurrent chronic conditions such as diabetes, heart disease or hypertension, explains Matthew McNabney, medical director at ElderPlus. They typically also have some kind of physical impairment; more than half of the enrollees have some degree of dementia.

"The beauty of PACE is that the incentives are all right," says ElderPlus Director Karen Armacost. The staff provides aggressive and creative preventive health care to keep seniors healthy and to avoid expensive hospitalizations or nursing home visits, goals that patients say they share.

"We pretty much say that PACE covers almost anything," says Smith, the Virginia long-term-care director.

Virginia has six PACE programs, and four more are planned, including the Inova site in Fairfax County. Virginia officials estimate that the cost to the state of a person who has

The Washington Post

Federal program aims to keep seniors out of hospitals and nursing homes

both Medicaid and Medicare through PACE is, on average, $4,200 less per year than that of a similar person getting Medicaid services either at home or in a nursing home.

Maryland officials aren't looking to expand PACE anytime soon, despite ElderPlus's waiting list - 87 as of last week.

One reason, Maryland officials say, is a dearth of organizations willing to sponsor such a program. To assume that financial responsibility, sponsors must be large health-care organizations, such as Johns Hopkins, or have sufficient resources to form a partnership with a health-care provider, they say.

Mark Leeds, the state director for Medicaid long-term-care services, says ElderPlus is "a good service, and people benefit from their participation," but he adds that before expanding PACE, the state would have "to make the numbers work."

In many parts of the country, PACE seems to be gaining popularity. The National PACE Association reports that 57 percent of sponsors are planning to expand their services. And the health-care overhaul law provides funds to test similar non-institutional alternatives for treating people who need long-term care.

In the District, Capitol Hill Village, which provides services to help its 350 members live independently in their own homes, has enlisted Volunteers of America Chesapeake, a regional human services organization, as a potential PACE sponsor. Washington Hospital Center's Medical House Call program is interested in becoming the medical partner.

In the PACE application that Inova submitted to Virginia officials, the hospital had to provide details about its business plan and medical services. But Inova also had to explain how it will cope with a problem Northern Virginia is famous for: daunting traffic that could compilicate getting seniors to a PACE site and back home.

"Someone could spend 50 minutes on a van and only go 10 to 15 miles," says Robert Hager, assistant vice president for long-term services at Inova. Seniors will probably go home early to beat the traffic.

The Washington Post

Federal program aims to keep seniors out of hospitals and nursing homes

Jaffe writes for Kaiser Health News, **specializing in health-care policy and aging issues. This article was produced through a collaboration between The Post and Kaiser Health News. KHN, an editorially independent news service, is a program of the Kaiser Family Foundation, a nonpartisan health-care-policy organization that is not affiliated with Kaiser Permanente.**

View all comments that have been posted about this article.

Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions

"Nobody Rushes You Through"

Chad Boult, MD, MPH, MBA
G. Darryl Wieland, PhD, MPH

Older patients with multiple chronic health conditions and complex health care needs often receive care that is fragmented, incomplete, inefficient, and ineffective. This article describes the case of an older woman whose case cannot be managed effectively through the customary approach of simply diagnosing and treating her individual diseases. Based on expert consensus about the available evidence, this article identifies 4 proactive, continuous processes that can substantially improve the primary care of community-dwelling older patients who have multiple chronic conditions: comprehensive assessment, evidence-based care planning and monitoring, promotion of patients' and (family caregivers') active engagement in care, and coordination of professionals in care of the patient—all tailored to the patient's goals and preferences. Three models of chronic care that include these processes and that appear to improve some aspects of the effectiveness and the efficiency of complex primary care—the Geriatric Resources for Assessment and Care of Elders (GRACE) model, Guided Care, and the Program of All-inclusive Care for the Elderly (PACE)—are described briefly, and steps toward their implementation are discussed.

JAMA. 2010;304(17):1936-1943 www.jama.com

PATIENT'S STORY

In late 2004, Ms N was a 77-year-old retiree. She had completed high school and worked for many years as a nursing assistant and a factory worker. Ms N lived alone in a modest senior housing apartment in a middle-class urban neighborhood. She received income from Social Security and support from her only child, a daughter who lived nearby. Her health insurance consisted of coverage by Medicare Parts A and B and her state's Medicaid program.

She had a history of hypertension with left ventricular hypertrophy, peripheral vascular disease with a left below-knee amputation, chronic obstructive pulmonary disease (COPD), glaucoma, keratitis, osteoarthritis with chronic right shoulder pain, and degenerative intervertebral disk disease. In conversation, she was alert, conversant, and oriented to time, place, and person. Physical examination did not detect abnormality of her heart, lungs, abdomen, nervous system, or skin. She had a well-healed left lower tibial stump and nonpalpable right dorsalis pedis and posterior tibial pulses. Her seated brachial blood pressure was 100/78 mm Hg; her intraocular pressures were 28 mm Hg (right eye) and 21 mm Hg (left eye). Her routine red and white blood cell counts, platelets, serum electrolytes, liver function studies, creatinine, and blood urea nitrogen values were normal.

Despite having a lower-leg prosthesis, she was nonambulatory and unable to shop, do housekeeping or laundry, drive, or use public transportation. She required assistance with food preparation, medication management, bathing, and transferring in and out of her wheelchair and bed. Her score on the Folstein Mini-Mental State Examination was 23 (out of a possible 30).

See also p 1948.

CME available online at www.jamaarchivescme.com and questions on p 1963.

Author Affiliations: Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland (Dr Boult); Palmetto Health Richland Hospital, Columbia, South Carolina (Dr Wieland).
Corresponding Author: Chad Boult, MD, MPH, MBA, 624 N Broadway, Room 693, Baltimore, MD 21205 (cboult@jhsph.edu).
Care of the Aging Patient: From Evidence to Action is produced and edited at the University of California, San Francisco, by Seth Landefeld, MD, Louise Walter, MD, C. Bree Johnston, MD, and Anna Chang, MD; Amy J. Markowitz, JD, is managing editor.
Care of the Aging Patient Section Editor: Margaret A. Winker, MD, Deputy Editor.

Ms N's prescribed medications included amlodipine, furosemide, potassium chloride, theophylline, albuterol, clopidogrel, enteric-coated aspirin, gabapentin, and quinine sulfate. She saw a primary care physician and an ophthalmologist regularly. She used a pill box to organize her medications, but she missed some doses nonetheless. She no longer smoked or used alcohol. She did not restrict her diet or engage in regular exercise or physical activity.

During 2002-2003, Ms N had been admitted to several hospitals and skilled nursing facilities for treatment of a ruptured lumbar intervertebral disk, *Clostridium difficile* colitis, an exacerbation of her COPD, and an ischemic foot ulcer that had become gangrenous. She had undergone a lumbar laminectomy, a left femoral-popliteal bypass procedure, a below-the-knee amputation, and prosthetic rehabilitation. She had received annual influenza vaccinations, but no screening tests. Her multiple chronic issues caused her daughter to refer her for eligibility evaluation to a local Program of All-Inclusive Care of the Elderly (PACE), where she was enrolled.

Ms N and her PACE primary care physician, Dr R, were interviewed by a Care of the Aging Patient editor in December 2009.

THE PATIENT'S NEEDS IN PERSPECTIVE

Ms N: *I had* [in 2004] *poor circulation, an amputation, emphysema, and arthritis in my right shoulder. I had a prosthesis, but it just wasn't working. It made my stump not sore but tender. I kept it off most of the time. I would only put it on if I had to go out.*

Dr R: *Her main thing was that she had severe peripheral vascular disease and a left below-knee amputation. Her stump was repeatedly breaking down, and she had very poor circulation in her right leg. Plus, she had several other chronic diseases, and she took 9 prescribed medications.*

Ms N is typical of the 10 million US residents who are older, living with 4 or more chronic health conditions, and in noninstitutional residences. Their lives (and sometimes their family caregivers' lives) are dominated by disease-related symptoms, disabilities, tests, treatments, and visits to health care clinicians. Their care is very costly, accounting for 80% of the Medicare program's annual expenditures.[1]

Good primary care physicians are often overwhelmed by the many needs for basic care in this population.[2] Medical school and residency training typically address provision of preventive services, care for acute illnesses and injuries, and diagnosis and treatment of 1 chronic disease at a time. However, many primary care physicians have not been trained to provide comprehensive care for patients with complex needs who have multiple chronic conditions, prescription medications, functional limitations, and a variety of health care professionals providing their care.[3]

Primary care physicians therefore face a perplexing dilemma—a steadily increasing number of chronically ill patients, but little opportunity to collaborate with the nurses, social workers, pharmacists, and rehabilitation therapists who could help meet the complex care needs of these patients. Underlying and exacerbating this crisis are 4 infrastructure deficiencies: (1) most primary care physicians and many other health professionals have not been trained to work in teams to provide complex chronic care; (2) sophisticated health information technologies, such as interoperative electronic health records, telemonitoring devices, and patient portals that could facilitate the essential processes of chronic care are not widely installed; (3) most current public and private health insurers' payment policies, which are based on fee-for-service payments, do not support the supplemental services provided by the newer models for providing complex chronic care; and (4) the payment for and the provision of medical and social services are separate and not integrated.

As a result, many primary care physicians cannot facilitate the essential components of high-quality, cost-effective, complex care for their chronically ill patients. Simply trying harder and working smarter cannot overcome these fundamental obstacles.

The consensus of experts, based on currently available evidence, indicates that high-quality, cost-effective health care for older patients with multiple chronic conditions is often associated with 4 concurrent, interacting processes that transcend and support the diagnosis and treatment of individual diseases.

- Comprehensive assessment of all of the patient's diseases, disabilities, cognitive abilities, medications, health-related devices, other treatments, self-care behaviors, health-related lifestyle habits, psychological conditions, environmental risks, family (or friend) supports, and other resources—plus the patient's relevant values and preferences for care.[4,5]
- Creation, implementation, and monitoring of a comprehensive, evidence-based plan of care that addresses all of the patient's health-related needs in the context of the patient's preferences.[5,6]
- Communication and coordination with all who provide care for the patient, including specialist physicians, hospital and emergency staff, rehabilitation therapists, mental health professionals, home care providers, social workers, and community-based agencies (eg, adult day health care facilities, exercise programs, and support groups)—especially during transitions between hospitals and other sites of care.[7]
- Promotion of the patient's (and caregiver's) active engagement in his or her health care—through self-management classes (when available) and ongoing encouragement, direction, and reinforcement.[8-11]

Unfortunately, mainstream primary care in the United States in 2010 rarely includes these 4 processes; therefore, patients with complex needs like Ms N often receive care that is noncomprehensive, nonevidence-based, frag-

mented, and inefficient.[12] Care is often further undermined by poor patient adherence[13,14] and limited assistance from families and friends.[15]

METHODS

The Evidence: The Effects of New Models of Primary Care

We searched MEDLINE for English-language articles published between September 1, 1999 and August 30, 2010, that reported the results of studies about the effects of US models of comprehensive primary care for older patients with multiple chronic conditions. We used the search terms: *primary health care, comprehensive health care, patient care team, care coordination, frail older adults, health services,* and *outcome assessment* (health care). From the articles identified, we selected those for which the abstract indicated that the reported analysis compared an intervention group with an equivalent concurrent control group to evaluate the effect of the intervention on quality of health care, quality of life or functional status, and the use or cost of health services. We excluded articles that reported the use of weak study designs (eg, historical controls), inadequate numbers of older participants with multiple chronic conditions, the use of unvalidated or unreliable measures, or inappropriate statistical analyses. We also searched the Web site of Mathematica Policy Research,[16] which contracted with the Centers for Medicare & Medicaid Services to evaluate the effect of PACE on the quality of care.

RESULTS OF EVIDENCE REVIEW

Complete results of the studies meeting the inclusion criteria are shown in the eTable (available at http://www.jama.com). A 12-month randomized controlled trial (RCT) measured the effects of home-based primary care among participants (N=1966) who were terminally ill and those who were not.[17] No effects on functional status (as measured by the Barthel Index or the Short Form-36 [SF-36]) were seen in either group. The nonterminally ill group had significantly better satisfaction with care on a number of parameters and better caregiver-rated SF-36 scores, compared with the control group. Caregivers in both groups reported significantly higher satisfaction with care. Total health care costs for participants who received home-based primary care were significantly higher than total costs for those who received usual care.

The Geriatric Resources for Assessment and Care of Elders (GRACE) model was evaluated in an RCT conducted over 2 years (N=951).[18] During the first year, participants receiving the GRACE intervention were significantly more likely than control participants to receive a flu shot (74% vs 67%), newly identify a primary care physician (81% vs 63%), have a follow-up primary care visit within 6 weeks of a hospital discharge (83% vs 54%), newly receive a medication list (58% vs 38%), and newly report having a health care representative or a living will (44% vs 17%).[19] Those receiving the GRACE intervention were also more likely to report the identification of, referral for, and receipt of information about geriatric conditions including difficulty walking or falls, urinary incontinence, depression, and hearing impairment (audiology or ear, nose, and throat clinic visits among individuals with baseline impairment).

After 2 years, there were no differences between the groups' performance of activies of daily living or instrumental activities of daily living, SF-36 Physical Component Summary scores, days spent in bed at home, or satisfaction with care, although the GRACE group's mean SF-36 Mental Component Summary score was significantly better (treatment effect [SE]=2.4 [10.5]).[20] Visits to emergency departments were reduced by 17% ($P=.03$), but the groups' admissions to hospitals and total health care costs were similar. In a preplanned analysis of a subgroup of participants at high risk of hospitalization (probability of repeated admission [PRA] score ≥ 0.4), the GRACE group had fewer hospital admissions in year 2, less cost related to hospitalization, more cost related to chronic and preventive care, no difference in total costs at 1 and 2 years, and lower total costs during year 3, at 1 year postintervention.[21]

Several effects of Guided Care were assessed in a cluster RCT (N=904). Boyd et al[22] used the Patient Assessment of Chronic Illness Care (PACIC) scale to measure care quality as experienced and reported by participants. After 18 months, participants were more likely to give high-quality ratings to Guided Care than to usual care (adjusted odds ratio [OR], 2.13; 95% confidence interval [CI], 1.30-3.50). In the same study, participants' family caregivers (N=196) also completed the PACIC in rating the quality of care provided to their care recipients.[23] Again, Guided Care was rated more highly on aggregate quality and most of the PACIC subscales; caregiver strain and depression did not differ between the groups. Using insurance claims from the first 8 months of this same cluster RCT (N=835), Leff et al[24] found trends toward reduced utilization and costs of health care by Guided Care patients, but the differences were not statistically significant. Marsteller et al[25] studied the effects of Guided Care on primary care physicians (N=49 physicians) during the first year of this same cluster RCT. This study found higher physician satisfaction with patient and family communication and better physician knowledge of patients' clinical characteristics, but no significant difference in physicians' ratings of other aspects of care.

PACE was evaluated in 1 cross-sectional time series and 3 cohort studies, each of which compared participants in the PACE group with control participants who were receiving different packages of medical and supportive services in their local communities. In the cross-sectional time series (N=1285; 20 107 person-months, comparisons unadjusted for any confounding),[26] PACE had significantly fewer hospital admissions and preventable hospital admissions per

thousand patients per month (35.7 vs 52.8, and 8.6 vs 13.3, respectively), as well as fewer total and preventable emergency department visits, compared with a community-based analog of PACE in which medical care was provided by independent primary care physicians (eTable). Differences in the groups' hospital days and average length of hospital stay were not statistically significant.

A 6-year cohort study (N=1215) compared PACE participants with similarly disabled Medicaid enrollees who were receiving community-based supportive services.[27] The final survey (2½-6 years after enrollment) indicated that PACE participants had less pain and fewer unmet needs for assistance in bathing, dressing, and getting around; the 2 groups did not differ significantly in self-rated health, difficulty performing activities of daily living, recent falls, weight loss, unmet needs for help with toileting and getting out of bed, and most behavioral problems (reported by proxies) and depressive symptoms. Satisfaction with personal assistance and the overall quality of medical care was similar. During the year before the survey, PACE participants were less likely to have been hospitalized and were more likely to have had a hearing screening, a vision screening, an influenza vaccination, and an advanced directive. PACE participants were more likely to have had a nursing home stay—probably reflecting PACE's use of nursing homes for subacute, postacute, and respite care.

A 12-month cohort study compared the use of hospital and nursing home services by participants in PACE and those in a Medicaid-sponsored, managed long-term care plan (N=2679).[28] PACE enrollees had fewer hospitalizations, more nursing home stays, and shorter median lengths of stay than participants receiving nurse-provided case management in the managed care plan. Finally, a 5-year cohort study (N=2040) found longer median survival among individuals enrolled in PACE than in those who received case management and community services. The difference was statistically significant among patients with high mortality risk at baseline.[29]

Studies of other US models of comprehensive primary care for complex older patients reported isolated promising findings, but they did not evaluate the outcomes required for inclusion in this review.[30-32] Modest findings were also identified from studies of related models in 3 countries with global health budgets: Canada,[33] Great Britain,[34] and the Netherlands.[35] These studies did not offer additional insights of value to the US health care system.

ALTERNATIVE MODELS OF CARE

Based on the literature review, 3 comprehensive primary care models appear to have the greatest potential to improve quality of care and quality of life for older patients with complex health care needs, while reducing or at least not increasing the costs of their health care: the GRACE model, Guided Care, and PACE. Each represents a different approach to enacting the 4 primary care processes described previously, and each incorporates several of the structural elements of the chronic care model for improving health-related outcomes for patients with multiple chronic conditions.[36,37]

How the Alternative Models Work

All 3 models are based on care by teams of professionals–including primary care physicians, registered nurses, and other health professionals–that are based in primary care settings. Teams in all 3 models provide many of the same services to older patients with complex health care needs including

- Comprehensive assessment
- Development of a comprehensive care plan that incorporates evidence-based protocols
- Implementation of the plan over time
- Proactive monitoring of the patient's clinical status and adherence to the care plan
- Coordination of primary care, specialty care, hospitals, emergency departments, skilled nursing facilities, other medical institutions, and community agencies
- Facilitation of the patient's transitions from hospitals to postacute settings
- Facilitation of the patient's access to community resources, such as meals programs, handicapped-accessible transportation, adult day care centers, support groups, and exercise programs

These models differ significantly, however, in other aspects of their structures and operations.

How the Alternative Models Differ

GRACE. In the GRACE model, primary care physicians and on-site support teams provide comprehensive primary care for low-income older patients receiving care through community health centers (TABLE). The support teams meet with off-site geriatrics interdisciplinary teams to review each patient's clinical status at least quarterly.[38] Most of the services provided by the support team and the geriatrics interdisciplinary team (average cost ≈ $105/patient per month) are not covered by fee-for-service Medicare, Medicaid, or private health insurance. Thus, primary care physicians' opportunities to use the GRACE model are currently limited to geographic areas[39] where practices participating in regional pilot tests or demonstrations of the "medical home" or "advanced primary care" concepts might incorporate GRACE resources to improve their care. Most of these programs are being conducted and funded by Medicare Advantage plans, large employers, the Veterans Health Administration, or private payers.

Guided Care. In the Guided Care model (Table), 2 to 5 primary care physicians partner with a registered nurse practicing at the same site, to provide comprehensive primary care to 55 to 60 older patients who are at high risk for using extensive health services during the following year. This risk is estimated by computing each patient's hierarchical con-

Table. Models of Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions

	GRACE	Guided Care	PACE
Year program began	2002	2006	1990
Primary care clinician	Established primary care physician	Established primary care physician	PACE staff physician[a]
Other team members	On-site advanced practice nurse and social worker; off-site geriatrician, physical therapist, mental health social worker, pharmacist, community liaison	Registered nurse	Registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, pharmacist, dietitian, home care coordinator, personal care aide, driver, site manager
Service base	Community-based health center	Primary care office	Day health center
Patient eligibility	Low-income	Hierarchical condition category score in highest quartile[b]	Certified as requiring long-term care
Frequency of contact	Monthly	Monthly	1-5 days per week
Services covered by			
Medicare	No[c]	No	Yes
Medicaid	No	No	Yes

Abbreviations: GRACE, Geriatric Resources for Assessment and Care of Elders; PACE, Program of All-Inclusive Care for the Elderly.
[a] At some sites, PACE contracts with community-based physicians.
[b] Indicates risk of using extensive health services during the following year.
[c] Only home visits by advanced practice nurses are covered.

dition category (HCC) score from the diagnoses on all health insurance claims generated by the patient during the past year.[40]

Each Guided Care nurse completes a 40-hour online course, earns the Certificate in Guided Care Nursing from the American Nurses Credentialing Center, and is employed by the practice. The nurse encourages patients to engage in productive health-related behaviors by helping them to create personal action plans, referring them to 6-session chronic disease self-management courses,[41] and using motivational interviewing[42] during their monthly contacts with the patients. The nurse also assesses family caregivers and provides them with educational material, suggestions, referral to community agencies, and emotional support.[43] Details about the Guided Care model are available in print[44] and on the Internet.[45]

The services of Guided Care nurses (average cost ≈ $150/patient per month) are not reimbursable under the fee-for-service Medicare program, state Medicaid programs, or most private insurance plans. Thus, as with the GRACE model, primary care physicians' opportunities to adopt Guided Care are now limited to geographic areas where regional pilot tests or demonstrations of the medical home or advanced primary care concepts are being conducted.[39] Technical assistance for primary care practices, including an implementation manual, a patient education booklet, and online courses for nurses, practice leaders, and primary care physicians, is now available.[44,46]

PACE. PACE provides many of the same care processes as the GRACE and Guided Care models, although it differs in terms of patient population, scope of services, organization, and financing. Each PACE site serves local patients who are aged 55 years or older and state certified as eligible for nursing home care, but able (with PACE services) to continue living safely in the community. Like Ms N, most patients (89%) are medically complex, low-income, and enrolled in both Medicare and Medicaid (ie, "dual eligibles"); unlike Ms N, however, most have disabilities that are irreversible. Approximately half have dementia, and more than half are dependent on others to help them with at least 3 basic activities of daily living.[47]

Each PACE site provides to its patients, either directly or by contract, a comprehensive set of services: primary, specialty, emergency, hospital, home, palliative, and institutional long-term care; case management, prescription drugs, dentistry, laboratory tests, radiology, adult day care, transportation, prosthetics, durable medical equipment, meals; and for family caregivers, respite, education and support. PACE participants are transported by PACE vans from their homes to the PACE day health center several times each week for health care, education, and social activities. PACE clinicians provide care in the PACE day health center and in patients' homes, assisted living facilities, and nursing homes. The PACE interdisciplinary team, which is based in the PACE day health center, includes a wide range of health professionals (Table). The largest PACE organization currently serves nearly 2400 patients, but most serve fewer than 300.[48-50]

Each PACE site operates as a managed care plan that receives capitated payments from Medicare and Medicaid and uses these funds to pay for all of the health-related services required by its patients. Since 1997, PACE has been recognized as a "provider" (as in physicians and hospitals) by the Medicare program, and all state Medicaid programs have had the option to recognize and contract with PACE organizations to provide care for eligible individuals enrolled in both Medicare and Medicaid. Despite PACE's attractive features, operational challenges have limited its geographic reach (recognition by 29 states) and aggregate size (21 000 patients).[51-53] In contrast, 600 000 similarly complex, dis-

abled persons receive supportive care at home through Medicaid "aged and disabled" service programs,[54] and 875 000 reside in nursing homes.[55,56]

THE PATIENT'S STORY, CONTINUED

Ms N met all of the local PACE program's requirements. She joined the local PACE in December 2004 and has received all of her care there for the past 6 years.

Ms N [in 2009]: *We are picked up from our homes. The drivers are patient and good with the seniors. The center has nice hot lunches, coffee, tea, and snacks. The doctors are patient. They have the time, and they give you the care you need. Nobody rushes you through. We also have music, brain words, drawing, sculpting, singing, exercise, and meditation. We are blessed to have all this.*

Dr R: *Ever since Ms N came to PACE in 2004, our physical therapist and I have paid close attention to her prosthesis; we've worked closely with a prosthetist. Now I forget that she has a prosthetic leg because she walks on it so well. We have also worked with her on her lipids, her emphysema, and her arthritis.*

The Process of Chronic Care

For the past 6 years, PACE has provided Ms N with all 4 of the concurrent, interacting processes needed to supplement the prevention and treatment of individual diseases to produce high-quality, cost-effective chronic care.

Comprehensive Assessment. Upon enrolling in PACE, Ms N underwent a multidisciplinary assessment by the PACE team: the medical director, a nurse practitioner, a nurse, a social worker, a pharmacist, a physical therapist, an occupational therapist, a dietician, and a nurse's aide. Besides clarifying her medical diagnoses, this assessment revealed previously undiagnosed depression, a poorly-fitting leg prosthesis, inadequately treated pain, suboptimal medication adherence, lack of exercise and social interaction, and excessive intake of dietary sodium and fat.

Evidence-Based Care Planning and Implementation. Beginning with published evidence-based guidelines, the PACE team collaborated in drafting a plan, consistent with Ms N's goals for care, for optimizing each of her conditions and health-related behaviors. Through the next several months, the team consulted a prosthetist for revision of her leg prosthesis and worked with Ms N and her daughter to rehabilitate the skin of her stump, begin physical therapy for her shoulder and back pain, reduce her intake of hydrocodone, improve her sleep, obtain a multidose medication box to organize her daily doses, recognize and treat the early signs of bacterial respiratory infection, begin a mild daily exercise routine, begin gradual reduction of sodium and fat in her diet, and join several ongoing social activities with other patients at the PACE day health center.

Coordination With Other Providers. Building on PACE's long-standing relationships with community providers, members of the PACE team collaborated with her ophthalmologist and her prosthetist in providing Ms N's ongoing care.

Patient and Family Engagement in Self-care. The PACE nurse helped Ms N to begin exercising, modifying her diet, and taking her medications consistently. The program nurse also provided Ms N's daughter with information about Ms N's health conditions and encouraged her to help her mother fulfill her crucial role in managing her health at home, eg, with proper diet, exercise, medication adherence, blood pressure checks, and early treatment of respiratory infections.

Ms N's Results

Ms N [in 2009]: *They got my prosthesis to fit so it's comfortable. It's no problem now. Most people don't even know I wear a prosthesis. I only take it off when I'm ready to go to bed. I love coming here. The nurses, the doctor, the physical therapists, everybody who works here, we are just one big family.*

Dr R: *I've been carefully treating her lipids to minimize progression of her peripheral vascular disease; it's been very stable since I met her 6 years ago. Her emphysema and shoulder arthritis have been well controlled, too. She's had zero hospitalizations since I've known her. At the first sign of trouble with her COPD or skin breakdown, we see her in clinic and start treatment right away.*

Six years after enrolling in PACE, Ms N continues to live independently, exercising 3 times each week, limiting the salt in her diet, and taking all of her doses of medication as prescribed.

The skin on her left leg stump and her right lower extremity is intact. Her blood pressure, serum lipid levels, and intraocular pressures are within the target ranges. The arthritic pain in her spine and right shoulder is well controlled, and her keratitis has resolved. She walks without assistance, performs most of her activities of daily living independently or with assistive devices, and receives assistance only with shopping, transportation, heavy chores, and bathing. She volunteers at the PACE center as a greeter for other patients.

During the 2 years before she enrolled in PACE, Ms N was admitted to hospitals several times for respiratory infections and 3 major nonelective surgical procedures, after which she spent many months receiving postacute wound care and prosthetic rehabilitation in skilled nursing facilities. During the 6 years after she enrolled in PACE, she has visited the hospital only once for an elective outpatient excision of a lipoma. Ms N's case is anecdotal but illustrates the ways in which the components of the PACE program addressed her multitude of issues in a systematic way—improving her independence and helping prevent hospital and nursing home admissions.

CHRONIC CARE IN PRIMARY CARE PRACTICE

Primary care physicians without access to GRACE and Guided Care options for their patients have a few alternatives. One is to refer eligible patients to a PACE site, if avail-

able,[57] but referred patients must usually transfer their medical care from their primary care physicians to PACE physicians. Another possible action for clinicians in states where PACE is a Medicaid-covered option is to support local coalitions that seek to establish local PACE sites. Those in other regions can urge their state Medicaid programs to designate PACE as a covered option.

Primary care physicians without these options can refer their chronically ill patients who need supportive services to local resources such as Area Agencies on Aging, state-sponsored home and community-based services (for Medicaid recipients), and other community-based voluntary and philanthropic service organizations. Unfortunately, such referrals seldom establish the bidirectional interactions between health care professions who provide medical and social services that are characteristic of GRACE, Guided Care, and PACE.[58]

Finally, some primary care clinicians may wish to transform their practices into medical homes, advanced primary care practices, or accountable care organizations that can provide cost-effective complex services to their chronically ill patients. However, such a transformation usually requires hiring new staff, acquiring health information technology, supplemental training of physicians and office staff, revamping workflows, and transient reductions in productivity. These costly changes generally are feasible only in the context of pilot programs or demonstrations that provide sufficient technical assistance and supplemental revenue to offset the costs of transformation and the practice's subsequent expanded clinical services. Many such pilot programs and demonstrations are in various stages of development or operation.[39]

As the United States implements new models of chronic care, such as the 3 described here, more research is needed to define the optimal methods for identifying the patients who will benefit most, for providing the essential clinical processes, for disseminating and expanding the reach of these models, and for paying for excellent chronic care. Also necessary will be significant advances in the education of health care professionals and the managerial infrastructure that underlies new models of care.[59,60]

As progress is made, in part through initiatives launched by the Patient Protection and Affordable Care Act of 2010, a growing cadre of US primary care providers will have new opportunities to care for their chronically ill patients more effectively and efficiently. They will more nearly meet the goals of maximizing patients' independence and function and reducing the need for admission to hospitals and nursing homes.

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Dear Member of the Joint Appropriations Committee on Health and Human Services:

Thank you for being a public servant at the Montana Legislature. I appreciate you considering the hard issues of public health on this committee as well.

My business directly benefits from the PACE program administered by the Billings Clinic. The newspaper says it is all about JOBS at this Legislature -- well, that is true for me, too -- my business is succeeding in part because of PACE. PACE assigns participants in the program to my company, Synergy HomeCare. The direct benefit is that I assign my employees to these participants. PACE is a partner and helps create jobs which benefits Synergy HomeCare and it's employees.

Please support the PACE program.

Sincerely,

PACE Contracted Care Provider

Brett Fellows

SYNERGY HomeCare Billings
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Billings, MT 59102
(406) 839-2390
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SYNERGY HomeCare

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2429 Mission Way Billings, MT 59102
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January 19, 2011

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of Montana

• SUPPORTED MINISTRIES •

Mission Ridge
Independent Living

The Vista At Mission Ridge
Assisted Living

Sapphire Lutheran Homes
of Hamilton

The Honorable Don Roberts, Chairman
Joint Appropriations Committee on Health and Human Services
Montana House of Representatives

Re: PACE Funding

Dear Chairman Roberts and Committee Members:

I write today in hopes that funding support for the Program of All-Inclusive Care for the Elderly (PACE) can be restored. Funding for this important program was eliminated from the Governor's Budget but I suspect that the long-term ramifications of this initial decision were not fully explored.

Billings Clinic is to be complimented for the risk they took in starting this demonstration program in partnership with the State of Montana and the Federal Government. I have long been a fan of PACE programming and have followed its national development, beginning with the On Lok community in San Francisco, for over 25 years. It has proven itself to be a cost effective way to deliver an integrated model of care to seniors who face a number of complicated chronic care issues. I remain convinced that it is a more cost effective way to deliver this important care than the traditional delivery system paid for by Medicaid and Medicare.

The challenge has always been... how can a PACE program can work in a rural state like Montana where our elderly population is so dispersed? Billings Clinic has undertaken the heavy lifting to demonstrate that it can work, we all just need to work together to make it successful. If we lose this current programming I believe the chance of PACE ever reestablishing itself as a cost effective alternative will disappear from the Montana landscape forever. The "graying" of Montana, combined with health care reform, would make this a significant loss.

St. John's does not have a stake in the PACE program but several of our Medicaid waiver residents living in independent or assisted living are clients of PACE. Without that support I expect that they and others will require nursing home care. Feel free to contact me directly at (406) 655-5612 if further support would be helpful.

Sincerely,

Kent Burgess
President & CEO

...nurturing environments of hope, dignity and love

RiverStone Health

Connecting you to a better life

January 19, 2011

The Honorable Don Roberts, Chairman
Joint Appropriations Committee on Health and Human Services
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

RE: PACE Program Support

Dear Chairman Roberts and Members of the Joint Appropriations Committee on Health and Human Services:

On behalf of RiverStone Health, Yellowstone County's public health organization, I urge you to support the Program of All-Inclusive Care for the Elderly – PACE. Earlier this month, you voted to accept the Department of Public Health and Human Services recommendation to eliminate funding for PACE as a part of the 5% budget reduction. As a provider of services via the Home and Community-Based waiver program (one also impacted by the 5% reduction decision), the elimination of PACE eliminates options and may lead to costly alternatives for healthcare.

Our organization has worked with Billings Clinic, which operates the PACE program for many years. PACE is a cost effective program because the Billings Clinic is responsible for the quality and cost of **ALL** care they provide as well as the quality and cost of care provided by those they contract with to provide services to PACE recipients. Monthly capitated payments from Medicare and Medicaid are pooled and care is provided following a comprehensive assessment of the participant's needs. PACE's inclusive single payment for all necessary care provides strong incentives to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and nursing home care.

Not only are there positive personal impacts for PACE clients, there are financial benefits to continuing this program. Without PACE, clients will be left without the benefit of a consolidated effort to help manage their healthcare needs which could lead to additional visits to healthcare providers as well as additional related costs.

Thank you for your reconsideration of PACE program funding. I look forward to working with you on this and other important public health measures. If you have any questions, please do not hesitate to contact me at barbara.sch@riverstonehealth.org or 651-6420.

Sincerely,

Barbara Schneeman, Director
Communication & Advocacy

RiverStone Health

Connecting you to a better life

Cc: Senators Mary Caferro, Dave Lewis, Jason Priest and Representatives Tony Belcourt, Tom Burnett, John Esp, Trudi Schmidt

Billings Clinic

January 19, 2011

The Honorable Don Roberts, Chairman
Joint Appropriations Committee on Health and Human Services
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

RE: PACE Program Support

Dear Chairman Roberts and Members of the Joint Appropriations Committee on Health and Human Services:

Thank you for your public service and the difficult work of serving on the Joint Appropriations Committee on Health and Human Services. I wanted to let you know of Billings Clinic's efforts to seek the committee's consideration of reinstating the $314,459. in the Senior and Long Term Care's budget, NP 55423, and avoid elimination of the PACE program--the Program for the All-Inclusive Care for the Elderly which has been operating for only two years in Yellowstone County through a 3-way contractual arrangement between Billings Clinic, the state (DPHHS) and the federal government (CMS). PACE is being targeted for elimination of its funding as part of the DPHHS department's budget reduction plans and the Governor's budget for the next biennium.

PACE programs function as a fully accountable care organization. They are responsible for the quality and cost of **ALL** care provided both directly and through contracted providers. Monthly capitated payments from Medicare and Medicaid are pooled and care is provided following a comprehensive assessment of the participant's needs. PACE's inclusive capitated single payment for all necessary care provides strong incentives to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and nursing home care.

Billings Clinic approached the state DPHHS in 2007 and encouraged them to offer this managed care option to the dual-eligible population in our state. After much investment, time and money, and learning how to deliver health care to a complex, high cost population on a fixed budget, we are faced with our Medicaid funding being eliminated, should the Governor's budget be enacted by the Legislature. The program will be forced to close. Billings Clinic believes this will be a short-sighted decision. We philosophically believe that to slow the growth of health care costs, it will require the direct engagement of health care organizations to incorporate care delivery changes that reduce unnecessary variation and improve coordination between all sites of care through payment models that pay for value, not volume of services.

PACE is recognized by CMS and it has permanent provider status in both Medicare and Medicaid. It is administered, from a regulatory perspective, under Medicare Part C and is considered a managed care program. There are currently more than 70 PACE programs in over 30 states. Billings Clinic became

interested in this care and capitated payment model as part of a Federal rural PACE expansion grant, as it was consistent with many of the concepts of health reform, emphasizing primary care, focusing on prevention and timely intervention, coordinating participants' care and bundling payment to encourage patient -centered care. To be eligible for PACE, the participant must be 55 years of age and older, live in Yellowstone County, certified by the state to need nursing home level of care and able to live safely in the community at the time of enrollment. As of January 2010 there are 52 participants in PACE locally and we expect over the next year to grow to 70. As part of the rural PACE demonstration grant we did operate a rural spoke PACE program in Livingston until December 2010. Achieving adequate enrollment was a challenge, in part due to the strict eligibility requirement of Medicaid in Montana. Without sufficient enrollment to cover our fixed costs we were forced to close that program and have worked with CMS and Medicaid to transition participants to appropriate levels of care. Last year we were excited to offer PACE to Veterans in Yellowstone County, through a national VA demonstration program offerred in selected states. That arrangement is dependent on the 3 way PACE provider agreement with Medicaid and Medicare, if the legislature choses not to reinstate dollars in the DPHHS budget for PACE, Montana Veterans, who have little community based support services available to them, will not have this option.

PACE programs focus on providing care to people with chronic and long-term care needs. **In other states where PACE operates, it is seen as a valuable resource for policymakers focused on improving the delivery of care to this high-need, high-cost population.** Other provider organizations in Montana have expressed interest in developing PACE programs in their communities as they work to build the competencies needed to survive with the payment and delivery system changes anticipated in comprehensive health care reform. PACE is a proved model for delivering improved outcomes and quality of care for persons with both complex, chronic diseases and long-term care needs. I have attached a recent article from the Journal of the American Medical Association which evaluated efficient models of chronic care for the elderly.

Sincerely,

Kristianne B. Wilson

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Cc: Senators Mary Caferro, Dave Lewis, Jason Priest and Representatives Tony Belcourt, Tom Burnett, John Esp, Trudi Schmidt

Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions

"Nobody Rushes You Through"

Chad Boult, MD, MPH, MBA

G. Darryl Wieland, PhD, MPH

Older patients with multiple chronic health conditions and complex health care needs often receive care that is fragmented, incomplete, inefficient, and ineffective. This article describes the case of an older woman whose case cannot be managed effectively through the customary approach of simply diagnosing and treating her individual diseases. Based on expert consensus about the available evidence, this article identifies 4 proactive, continuous processes that can substantially improve the primary care of community-dwelling older patients who have multiple chronic conditions: comprehensive assessment, evidence-based care planning and monitoring, promotion of patients' and (family caregivers') active engagement in care, and coordination of professionals in care of the patient—all tailored to the patient's goals and preferences. Three models of chronic care that include these processes and that appear to improve some aspects of the effectiveness and the efficiency of complex primary care—the Geriatric Resources for Assessment and Care of Elders (GRACE) model, Guided Care, and the Program of All-inclusive Care for the Elderly (PACE)—are described briefly, and steps toward their implementation are discussed.

JAMA. 2010;304(17):1936-1943 www.jama.com

PATIENT'S STORY

In late 2004, Ms N was a 77-year-old retiree. She had completed high school and worked for many years as a nursing assistant and a factory worker. Ms N lived alone in a modest senior housing apartment in a middle-class urban neighborhood. She received income from Social Security and support from her only child, a daughter who lived nearby. Her health insurance consisted of coverage by Medicare Parts A and B and her state's Medicaid program.

She had a history of hypertension with left ventricular hypertrophy, peripheral vascular disease with a left below-knee amputation, chronic obstructive pulmonary disease (COPD), glaucoma, keratitis, osteoarthritis with chronic right shoulder pain, and degenerative intervertebral disk disease. In conversation, she was alert, conversant, and oriented to time, place, and person. Physical examination did not detect abnormality of her heart, lungs, abdomen, nervous system, or skin. She had a well-healed left lower tibial stump and nonpalpable right dorsalis pedis and posterior tibial pulses. Her seated brachial blood pressure was 100/78 mm Hg; her intraocular pressures were 28 mm Hg (right eye) and 21 mm Hg (left eye). Her routine red and white blood cell counts, platelets, serum electrolytes, liver function studies, creatinine, and blood urea nitrogen values were normal.

Despite having a lower-leg prosthesis, she was nonambulatory and unable to shop, do housekeeping or laundry, drive, or use public transportation. She required assistance with food preparation, medication management, bathing, and transferring in and out of her wheelchair and bed. Her score on the Folstein Mini-Mental State Examination was 23 (out of a possible 30).

See also p 1948.

CME available online at www.jamaarchivescme.com and questions on p 1963.

Author Affiliations: Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland (Dr Boult); Palmetto Health Richland Hospital, Columbia, South Carolina (Dr Wieland).

Corresponding Author: Chad Boult, MD, MPH, MBA, 624 N Broadway, Room 693, Baltimore, MD 21205 (cboult@jhsph.edu).

Care of the Aging Patient: From Evidence to Action is produced and edited at the University of California, San Francisco, by Seth Landefeld, MD, Louise Walter, MD, C. Bree Johnston, MD, and Anna Chang, MD; Amy J. Markowitz, JD, is managing editor.

Care of the Aging Patient Section Editor: Margaret A. Winker, MD, Deputy Editor.

Ms N's prescribed medications included amlodipine, furosemide, potassium chloride, theophylline, albuterol, clopidogrel, enteric-coated aspirin, gabapentin, and quinine sulfate. She saw a primary care physician and an ophthalmologist regularly. She used a pill box to organize her medications, but she missed some doses nonetheless. She no longer smoked or used alcohol. She did not restrict her diet or engage in regular exercise or physical activity.

During 2002-2003, Ms N had been admitted to several hospitals and skilled nursing facilities for treatment of a ruptured lumbar intervertebral disk, *Clostridium difficile* colitis, an exacerbation of her COPD, and an ischemic foot ulcer that had become gangrenous. She had undergone a lumbar laminectomy, a left femoral-popliteal bypass procedure, a below-the-knee amputation, and prosthetic rehabilitation. She had received annual influenza vaccinations, but no screening tests. Her multiple chronic issues caused her daughter to refer her for eligibility evaluation to a local Program of All-Inclusive Care of the Elderly (PACE), where she was enrolled.

Ms N and her PACE primary care physician, Dr R, were interviewed by a Care of the Aging Patient editor in December 2009.

THE PATIENT'S NEEDS IN PERSPECTIVE

Ms N: *I had* [in 2004] *poor circulation, an amputation, emphysema, and arthritis in my right shoulder. I had a prosthesis, but it just wasn't working. It made my stump not sore but tender. I kept it off most of the time. I would only put it on if I had to go out.*

Dr R: *Her main thing was that she had severe peripheral vascular disease and a left below-knee amputation. Her stump was repeatedly breaking down, and she had very poor circulation in her right leg. Plus, she had several other chronic diseases, and she took 9 prescribed medications.*

Ms N is typical of the 10 million US residents who are older, living with 4 or more chronic health conditions, and in noninstitutional residences. Their lives (and sometimes their family caregivers' lives) are dominated by disease-related symptoms, disabilities, tests, treatments, and visits to health care clinicians. Their care is very costly, accounting for 80% of the Medicare program's annual expenditures.[1]

Good primary care physicians are often overwhelmed by the many needs for basic care in this population.[2] Medical school and residency training typically address provision of preventive services, care for acute illnesses and injuries, and diagnosis and treatment of 1 chronic disease at a time. However, many primary care physicians have not been trained to provide comprehensive care for patients with complex needs who have multiple chronic conditions, prescription medications, functional limitations, and a variety of health care professionals providing their care.[3]

Primary care physicians therefore face a perplexing dilemma—a steadily increasing number of chronically ill patients, but little opportunity to collaborate with the nurses, social workers, pharmacists, and rehabilitation therapists who could help meet the complex care needs of these patients. Underlying and exacerbating this crisis are 4 infrastructure deficiencies: (1) most primary care physicians and many other health professionals have not been trained to work in teams to provide complex chronic care; (2) sophisticated health information technologies, such as interoperative electronic health records, telemonitoring devices, and patient portals that could facilitate the essential processes of chronic care are not widely installed; (3) most current public and private health insurers' payment policies, which are based on fee-for-service payments, do not support the supplemental services provided by the newer models for providing complex chronic care; and (4) the payment for and the provision of medical and social services are separate and not integrated.

As a result, many primary care physicians cannot facilitate the essential components of high-quality, cost-effective, complex care for their chronically ill patients. Simply trying harder and working smarter cannot overcome these fundamental obstacles.

The consensus of experts, based on currently available evidence, indicates that high-quality, cost-effective health care for older patients with multiple chronic conditions is often associated with 4 concurrent, interacting processes that transcend and support the diagnosis and treatment of individual diseases.

- Comprehensive assessment of all of the patient's diseases, disabilities, cognitive abilities, medications, health-related devices, other treatments, self-care behaviors, health-related lifestyle habits, psychological conditions, environmental risks, family (or friend) supports, and other resources—plus the patient's relevant values and preferences for care.[4,5]
- Creation, implementation, and monitoring of a comprehensive, evidence-based plan of care that addresses all of the patient's health-related needs in the context of the patient's preferences.[5,6]
- Communication and coordination with all who provide care for the patient, including specialist physicians, hospital and emergency staff, rehabilitation therapists, mental health professionals, home care providers, social workers, and community-based agencies (eg, adult day health care facilities, exercise programs, and support groups)—especially during transitions between hospitals and other sites of care.[7]
- Promotion of the patient's (and caregiver's) active engagement in his or her health care—through self-management classes (when available) and ongoing encouragement, direction, and reinforcement.[8-11]

Unfortunately, mainstream primary care in the United States in 2010 rarely includes these 4 processes; therefore, patients with complex needs like Ms N often receive care that is noncomprehensive, nonevidence-based, frag-

mented, and inefficient.[12] Care is often further undermined by poor patient adherence[13,14] and limited assistance from families and friends.[15]

METHODS

The Evidence: The Effects of New Models of Primary Care

We searched MEDLINE for English-language articles published between September 1, 1999 and August 30, 2010, that reported the results of studies about the effects of US models of comprehensive primary care for older patients with multiple chronic conditions. We used the search terms: *primary health care, comprehensive health care, patient care team, care coordination, frail older adults, health services*, and *outcome assessment* (health care). From the articles identified, we selected those for which the abstract indicated that the reported analysis compared an intervention group with an equivalent concurrent control group to evaluate the effect of the intervention on quality of health care, quality of life or functional status, and the use or cost of health services. We excluded articles that reported the use of weak study designs (eg, historical controls), inadequate numbers of older participants with multiple chronic conditions, the use of unvalidated or unreliable measures, or inappropriate statistical analyses. We also searched the Web site of Mathematica Policy Research,[16] which contracted with the Centers for Medicare & Medicaid Services to evaluate the effect of PACE on the quality of care.

RESULTS OF EVIDENCE REVIEW

Complete results of the studies meeting the inclusion criteria are shown in the eTable (available at http://www.jama.com). A 12-month randomized controlled trial (RCT) measured the effects of home-based primary care among participants (N=1966) who were terminally ill and those who were not.[17] No effects on functional status (as measured by the Barthel Index or the Short Form-36 [SF-36]) were seen in either group. The nonterminally ill group had significantly better satisfaction with care on a number of parameters and better caregiver-rated SF-36 scores, compared with the control group. Caregivers in both groups reported significantly higher satisfaction with care. Total health care costs for participants who received home-based primary care were significantly higher than total costs for those who received usual care.

The Geriatric Resources for Assessment and Care of Elders (GRACE) model was evaluated in an RCT conducted over 2 years (N=951).[18] During the first year, participants receiving the GRACE intervention were significantly more likely than control participants to receive a flu shot (74% vs 67%), newly identify a primary care physician (81% vs 63%), have a follow-up primary care visit within 6 weeks of a hospital discharge (83% vs 54%), newly receive a medication list (58% vs 38%), and newly report having a health care representative or a living will (44% vs 17%).[19] Those receiving the GRACE intervention were also more likely to report the identification of, referral for, and receipt of information about geriatric conditions including difficulty walking or falls, urinary incontinence, depression, and hearing impairment (audiology or ear, nose, and throat clinic visits among individuals with baseline impairment).

After 2 years, there were no differences between the groups' performance of activies of daily living or instrumental activities of daily living, SF-36 Physical Component Summary scores, days spent in bed at home, or satisfaction with care, although the GRACE group's mean SF-36 Mental Component Summary score was significantly better (treatment effect [SE] = 2.4 [10.5]).[20] Visits to emergency departments were reduced by 17% ($P=.03$), but the groups' admissions to hospitals and total health care costs were similar. In a preplanned analysis of a subgroup of participants at high risk of hospitalization (probability of repeated admission [PRA] score ≥ 0.4), the GRACE group had fewer hospital admissions in year 2, less cost related to hospitalization, more cost related to chronic and preventive care, no difference in total costs at 1 and 2 years, and lower total costs during year 3, at 1 year postintervention.[21]

Several effects of Guided Care were assessed in a cluster RCT (N=904). Boyd et al[22] used the Patient Assessment of Chronic Illness Care (PACIC) scale to measure care quality as experienced and reported by participants. After 18 months, participants were more likely to give high-quality ratings to Guided Care than to usual care (adjusted odds ratio [OR], 2.13; 95% confidence interval [CI], 1.30-3.50). In the same study, participants' family caregivers (N=196) also completed the PACIC in rating the quality of care provided to their care recipients.[23] Again, Guided Care was rated more highly on aggregate quality and most of the PACIC subscales; caregiver strain and depression did not differ between the groups. Using insurance claims from the first 8 months of this same cluster RCT (N=835), Leff et al[24] found trends toward reduced utilization and costs of health care by Guided Care patients, but the differences were not statistically significant. Marsteller et al[25] studied the effects of Guided Care on primary care physicians (N=49 physicians) during the first year of this same cluster RCT. This study found higher physician satisfaction with patient and family communication and better physician knowledge of patients' clinical characteristics, but no significant difference in physicians' ratings of other aspects of care.

PACE was evaluated in 1 cross-sectional time series and 3 cohort studies, each of which compared participants in the PACE group with control participants who were receiving different packages of medical and supportive services in their local communities. In the cross-sectional time series (N=1285; 20 107 person-months, comparisons unadjusted for any confounding),[26] PACE had significantly fewer hospital admissions and preventable hospital admissions per

thousand patients per month (35.7 vs 52.8, and 8.6 vs 13.3, respectively), as well as fewer total and preventable emergency department visits, compared with a community-based analog of PACE in which medical care was provided by independent primary care physicians (eTable). Differences in the groups' hospital days and average length of hospital stay were not statistically significant.

A 6-year cohort study (N=1215) compared PACE participants with similarly disabled Medicaid enrollees who were receiving community-based supportive services.[27] The final survey (2½-6 years after enrollment) indicated that PACE participants had less pain and fewer unmet needs for assistance in bathing, dressing, and getting around; the 2 groups did not differ significantly in self-rated health, difficulty performing activities of daily living, recent falls, weight loss, unmet needs for help with toileting and getting out of bed, and most behavioral problems (reported by proxies) and depressive symptoms. Satisfaction with personal assistance and the overall quality of medical care was similar. During the year before the survey, PACE participants were less likely to have been hospitalized and were more likely to have had a hearing screening, a vision screening, an influenza vaccination, and an advanced directive. PACE participants were more likely to have had a nursing home stay—probably reflecting PACE's use of nursing homes for subacute, postacute, and respite care.

A 12-month cohort study compared the use of hospital and nursing home services by participants in PACE and those in a Medicaid-sponsored, managed long-term care plan (N=2679).[28] PACE enrollees had fewer hospitalizations, more nursing home stays, and shorter median lengths of stay than participants receiving nurse-provided case management in the managed care plan. Finally, a 5-year cohort study (N=2040) found longer median survival among individuals enrolled in PACE than in those who received case management and community services. The difference was statistically significant among patients with high mortality risk at baseline.[29]

Studies of other US models of comprehensive primary care for complex older patients reported isolated promising findings, but they did not evaluate the outcomes required for inclusion in this review.[30-32] Modest findings were also identified from studies of related models in 3 countries with global health budgets: Canada,[33] Great Britain,[34] and the Netherlands.[35] These studies did not offer additional insights of value to the US health care system.

ALTERNATIVE MODELS OF CARE

Based on the literature review, 3 comprehensive primary care models appear to have the greatest potential to improve quality of care and quality of life for older patients with complex health care needs, while reducing or at least not increasing the costs of their health care: the GRACE model, Guided Care, and PACE. Each represents a different approach to enacting the 4 primary care processes described previously, and each incorporates several of the structural elements of the chronic care model for improving health-related outcomes for patients with multiple chronic conditions.[36,37]

How the Alternative Models Work

All 3 models are based on care by teams of professionals—including primary care physicians, registered nurses, and other health professionals—that are based in primary care settings. Teams in all 3 models provide many of the same services to older patients with complex health care needs including

- Comprehensive assessment
- Development of a comprehensive care plan that incorporates evidence-based protocols
- Implementation of the plan over time
- Proactive monitoring of the patient's clinical status and adherence to the care plan
- Coordination of primary care, specialty care, hospitals, emergency departments, skilled nursing facilities, other medical institutions, and community agencies
- Facilitation of the patient's transitions from hospitals to postacute settings
- Facilitation of the patient's access to community resources, such as meals programs, handicapped-accessible transportation, adult day care centers, support groups, and exercise programs

These models differ significantly, however, in other aspects of their structures and operations.

How the Alternative Models Differ

GRACE. In the GRACE model, primary care physicians and on-site support teams provide comprehensive primary care for low-income older patients receiving care through community health centers (TABLE). The support teams meet with off-site geriatrics interdisciplinary teams to review each patient's clinical status at least quarterly.[38] Most of the services provided by the support team and the geriatrics interdisciplinary team (average cost ≈ $105/patient per month) are not covered by fee-for-service Medicare, Medicaid, or private health insurance. Thus, primary care physicians' opportunities to use the GRACE model are currently limited to geographic areas[39] where practices participating in regional pilot tests or demonstrations of the "medical home" or "advanced primary care" concepts might incorporate GRACE resources to improve their care. Most of these programs are being conducted and funded by Medicare Advantage plans, large employers, the Veterans Health Administration, or private payers.

Guided Care. In the Guided Care model (Table), 2 to 5 primary care physicians partner with a registered nurse practicing at the same site, to provide comprehensive primary care to 55 to 60 older patients who are at high risk for using extensive health services during the following year. This risk is estimated by computing each patient's hierarchical con-

Table. Models of Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions

	GRACE	Guided Care	PACE
Year program began	2002	2006	1990
Primary care clinician	Established primary care physician	Established primary care physician	PACE staff physician[a]
Other team members	On-site advanced practice nurse and social worker; off-site geriatrician, physical therapist, mental health social worker, pharmacist, community liaison	Registered nurse	Registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, pharmacist, dietitian, home care coordinator, personal care aide, driver, site manager
Service base	Community-based health center	Primary care office	Day health center
Patient eligibility	Low-income	Hierarchical condition category score in highest quartile[b]	Certified as requiring long-term care
Frequency of contact	Monthly	Monthly	1-5 days per week
Services covered by			
Medicare	No[c]	No	Yes
Medicaid	No	No	Yes

Abbreviations: GRACE, Geriatric Resources for Assessment and Care of Elders; PACE, Program of All-Inclusive Care for the Elderly.
[a] At some sites, PACE contracts with community-based physicians.
[b] Indicates risk of using extensive health services during the following year.
[c] Only home visits by advanced practice nurses are covered.

dition category (HCC) score from the diagnoses on all health insurance claims generated by the patient during the past year.[40]

Each Guided Care nurse completes a 40-hour online course, earns the Certificate in Guided Care Nursing from the American Nurses Credentialing Center, and is employed by the practice. The nurse encourages patients to engage in productive health-related behaviors by helping them to create personal action plans, referring them to 6-session chronic disease self-management courses,[41] and using motivational interviewing[42] during their monthly contacts with the patients. The nurse also assesses family caregivers and provides them with educational material, suggestions, referral to community agencies, and emotional support.[43] Details about the Guided Care model are available in print[44] and on the Internet.[45]

The services of Guided Care nurses (average cost ≈ $150/patient per month) are not reimbursable under the fee-for-service Medicare program, state Medicaid programs, or most private insurance plans. Thus, as with the GRACE model, primary care physicians' opportunities to adopt Guided Care are now limited to geographic areas where regional pilot tests or demonstrations of the medical home or advanced primary care concepts are being conducted.[39] Technical assistance for primary care practices, including an implementation manual, a patient education booklet, and online courses for nurses, practice leaders, and primary care physicians, is now available.[44,46]

PACE. PACE provides many of the same care processes as the GRACE and Guided Care models, although it differs in terms of patient population, scope of services, organization, and financing. Each PACE site serves local patients who are aged 55 years or older and state certified as eligible for nursing home care, but able (with PACE services) to continue living safely in the community. Like Ms N, most patients (89%) are medically complex, low-income, and enrolled in both Medicare and Medicaid (ie, "dual eligibles"); unlike Ms N, however, most have disabilities that are irreversible. Approximately half have dementia, and more than half are dependent on others to help them with at least 3 basic activities of daily living.[47]

Each PACE site provides to its patients, either directly or by contract, a comprehensive set of services: primary, specialty, emergency, hospital, home, palliative, and institutional long-term care; case management, prescription drugs, dentistry, laboratory tests, radiology, adult day care, transportation, prosthetics, durable medical equipment, meals; and for family caregivers, respite, education and support. PACE participants are transported by PACE vans from their homes to the PACE day health center several times each week for health care, education, and social activities. PACE clinicians provide care in the PACE day health center and in patients' homes, assisted living facilities, and nursing homes. The PACE interdisciplinary team, which is based in the PACE day health center, includes a wide range of health professionals (Table). The largest PACE organization currently serves nearly 2400 patients, but most serve fewer than 300.[48-50]

Each PACE site operates as a managed care plan that receives capitated payments from Medicare and Medicaid and uses these funds to pay for all of the health-related services required by its patients. Since 1997, PACE has been recognized as a "provider" (as in physicians and hospitals) by the Medicare program, and all state Medicaid programs have had the option to recognize and contract with PACE organizations to provide care for eligible individuals enrolled in both Medicare and Medicaid. Despite PACE's attractive features, operational challenges have limited its geographic reach (recognition by 29 states) and aggregate size (21 000 patients).[51-53] In contrast, 600 000 similarly complex, dis-

abled persons receive supportive care at home through Medicaid "aged and disabled" service programs,[34] and 875 000 reside in nursing homes.[35,36]

THE PATIENT'S STORY, CONTINUED

Ms N met all of the local PACE program's requirements. She joined the local PACE in December 2004 and has received all of her care there for the past 6 years.

Ms N [in 2009]: *We are picked up from our homes. The drivers are patient and good with the seniors. The center has nice hot lunches, coffee, tea, and snacks. The doctors are patient. They have the time, and they give you the care you need. Nobody rushes you through. We also have music, brain words, drawing, sculpting, singing, exercise, and meditation. We are blessed to have all this.*

Dr R: *Ever since Ms N came to PACE in 2004, our physical therapist and I have paid close attention to her prosthesis; we've worked closely with a prosthetist. Now I forget that she has a prosthetic leg because she walks on it so well. We have also worked with her on her lipids, her emphysema, and her arthritis.*

The Process of Chronic Care

For the past 6 years, PACE has provided Ms N with all 4 of the concurrent, interacting processes needed to supplement the prevention and treatment of individual diseases to produce high-quality, cost-effective chronic care.

Comprehensive Assessment. Upon enrolling in PACE, Ms N underwent a multidisciplinary assessment by the PACE team: the medical director, a nurse practitioner, a nurse, a social worker, a pharmacist, a physical therapist, an occupational therapist, a dietician, and a nurse's aide. Besides clarifying her medical diagnoses, this assessment revealed previously undiagnosed depression, a poorly-fitting leg prosthesis, inadequately treated pain, suboptimal medication adherence, lack of exercise and social interaction, and excessive intake of dietary sodium and fat.

Evidence-Based Care Planning and Implementation. Beginning with published evidence-based guidelines, the PACE team collaborated in drafting a plan, consistent with Ms N's goals for care, for optimizing each of her conditions and health-related behaviors. Through the next several months, the team consulted a prosthetist for revision of her leg prosthesis and worked with Ms N and her daughter to rehabilitate the skin of her stump, begin physical therapy for her shoulder and back pain, reduce her intake of hydrocodone, improve her sleep, obtain a multidose medication box to organize her daily doses, recognize and treat the early signs of bacterial respiratory infection, begin a mild daily exercise routine, begin gradual reduction of sodium and fat in her diet, and join several ongoing social activities with other patients at the PACE day health center.

Coordination With Other Providers. Building on PACE's long-standing relationships with community providers, members of the PACE team collaborated with her ophthalmologist and her prosthetist in providing Ms N's ongoing care.

Patient and Family Engagement in Self-care. The PACE nurse helped Ms N to begin exercising, modifying her diet, and taking her medications consistently. The program nurse also provided Ms N's daughter with information about Ms N's health conditions and encouraged her to help her mother fulfill her crucial role in managing her health at home, eg, with proper diet, exercise, medication adherence, blood pressure checks, and early treatment of respiratory infections.

Ms N's Results

Ms N [in 2009]: *They got my prosthesis to fit so it's comfortable. It's no problem now. Most people don't even know I wear a prosthesis. I only take it off when I'm ready to go to bed. I love coming here. The nurses, the doctor, the physical therapists, everybody who works here, we are just one big family.*

Dr R: *I've been carefully treating her lipids to minimize progression of her peripheral vascular disease; it's been very stable since I met her 6 years ago. Her emphysema and shoulder arthritis have been well controlled, too. She's had zero hospitalizations since I've known her. At the first sign of trouble with her COPD or skin breakdown, we see her in clinic and start treatment right away.*

Six years after enrolling in PACE, Ms N continues to live independently, exercising 3 times each week, limiting the salt in her diet, and taking all of her doses of medication as prescribed.

The skin on her left leg stump and her right lower extremity is intact. Her blood pressure, serum lipid levels, and intraocular pressures are within the target ranges. The arthritic pain in her spine and right shoulder is well controlled, and her keratitis has resolved. She walks without assistance, performs most of her activities of daily living independently or with assistive devices, and receives assistance only with shopping, transportation, heavy chores, and bathing. She volunteers at the PACE center as a greeter for other patients.

During the 2 years before she enrolled in PACE, Ms N was admitted to hospitals several times for respiratory infections and 3 major nonelective surgical procedures, after which she spent many months receiving postacute wound care and prosthetic rehabilitation in skilled nursing facilities. During the 6 years after she enrolled in PACE, she has visited the hospital only once for an elective outpatient excision of a lipoma. Ms N's case is anecdotal but illustrates the ways in which the components of the PACE program addressed her multitude of issues in a systematic way—improving her independence and helping prevent hospital and nursing home admissions.

CHRONIC CARE IN PRIMARY CARE PRACTICE

Primary care physicians without access to GRACE and Guided Care options for their patients have a few alternatives. One is to refer eligible patients to a PACE site, if avail-

able,[57] but referred patients must usually transfer their medical care from their primary care physicians to PACE physicians. Another possible action for clinicians in states where PACE is a Medicaid-covered option is to support local coalitions that seek to establish local PACE sites. Those in other regions can urge their state Medicaid programs to designate PACE as a covered option.

Primary care physicians without these options can refer their chronically ill patients who need supportive services to local resources such as Area Agencies on Aging, state-sponsored home and community-based services (for Medicaid recipients), and other community-based voluntary and philanthropic service organizations. Unfortunately, such referrals seldom establish the bidirectional interactions between health care professions who provide medical and social services that are characteristic of GRACE, Guided Care, and PACE.[58]

Finally, some primary care clinicians may wish to transform their practices into medical homes, advanced primary care practices, or accountable care organizations that can provide cost-effective complex services to their chronically ill patients. However, such a transformation usually requires hiring new staff, acquiring health information technology, supplemental training of physicians and office staff, revamping workflows, and transient reductions in productivity. These costly changes generally are feasible only in the context of pilot programs or demonstrations that provide sufficient technical assistance and supplemental revenue to offset the costs of transformation and the practice's subsequent expanded clinical services. Many such pilot programs and demonstrations are in various stages of development or operation.[39]

As the United States implements new models of chronic care, such as the 3 described here, more research is needed to define the optimal methods for identifying the patients who will benefit most, for providing the essential clinical processes, for disseminating and expanding the reach of these models, and for paying for excellent chronic care. Also necessary will be significant advances in the education of health care professionals and the managerial infrastructure that underlies new models of care.[59,60]

As progress is made, in part through initiatives launched by the Patient Protection and Affordable Care Act of 2010, a growing cadre of US primary care providers will have new opportunities to care for their chronically ill patients more effectively and efficiently. They will more nearly meet the goals of maximizing patients' independence and function and reducing the need for admission to hospitals and nursing homes.

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From: Michelle Olson [mtaccent@wtp.net]
Sent: Tuesday, January 18, 2011 11:35 AM
To: davelewisd@aol.com; tbelcourt@hotmail.com; burnett.tom@gmail.com; marycaferro@gmail.com; jesp@mtintouch.net; jason@priest2010.com; trudischmidt@q.com; lsteinbeck@mt.gov; mdaumiller@mt.gov; mdaumiller@mt.gov; kwilkinson@mt.gov
Subject: DPHHS/Senior and Long Term Care budget

Dear Member of the Joint Appropriations Committee on Health and Human Services:

Thank you for taking the time to read my letter and serve the State of Montana. I am writing to ask you to **support and fund the PACE program** as a community member who has seen the positive impact of this program.

My friends and neighbors benefit from PACE providing an alternative care model. **Please support PACE** and remember this is a proven approach that is good for our Montana elderly population! This week's Billings Gazette pointed out that Montana will soon have the 4th largest elderly population in the United States. This is another reason the PACE program must be maintained for the elderly in Montana.

Thank you for listening and for your consideration regarding this important matter.

Sincerely,

Michelle Olson
839 Wyoming Ave.
Billings, MT 59101

PS: Since your committee chairperson – Don Roberts does not have an e-mail, PLEASE share my concerns with him.

January 17, 2010

Representative Don Roberts
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

Dear Member of the Joint Appropriations Committee on Health and Human Services:

I am writing this letter with sincere gratitude for your public service to your fellow Montanans. Thank you for serving us at the Montana Legislature.

I am aware that DPHHS has recommended the elimination of the PACE program in Montana. The PACE program offers medical and social services to many Montanans who otherwise would go without.

I own a small assisted living facility in Billings. We currently have two residents residing at our assisted living facility that are enrolled in the PACE program. I get to see first-hand what the benefits of the PACE program are.

For our business PACE pays us monthly rent; which in turn allows me to pay my staff. For the PACE participants the benefits are numerous: they receive frequent medical check-ups and medication management; they receive incontinent products and other soft-goods; they receive socialization and observation when at the Day Center; and we all receive 24/7 support and on-call services.

Please consider the families of PACE participants who need PACE to be able to continue to care for their loved ones; please consider PACE care and residential providers when you consider saving jobs for Montanans.

Please support the PACE program.

Sincerely,

Joanna K. Aspinwall, RN
Owner/Administrator
Forest Ridge Assisted Living Facility
3201 Rugby Drive, Billings, MT 59102

I am a cousin of Clark Swan, who is making a presentation to you today on behalf of his dear wife, Sharon. He has asked me for my support and I am most willing to do so through the story of my daughter, who, like Sharon, is most deserving of living her life to the best of her abilities in a nurturing, supportive environment. My daughter and I have not been personally assisted by PACE, but I want to briefly share our experiences. Danielle is 25 years old, has Autism, and lives at home, sharing time during the week between my home and my ex-husband's/her father's home. She is on a Medicaid Waiver program that enables her to attend a day program 2 days per week, as well as having other listed services under her Medicaid plan that are suppose to help her learn independence skills.

But in the past 2 years her Medicaid plan's finances have been drastically cut. It is impossible to find any service providers at the terribly low rate Medicaid would pay. And so her father and I have had to drastically cut back our hours at our jobs to ensure we are at home when she is at home, because she cannot be left alone.

Danielle wants to be independent (with supports) and as a 25 year old woman she is entitled to that right - independence and living in her community, under the Olmstead Act. But it is proving to be almost impossible to make that happen with the limited funding she receives from Medicaid. Independence skills are being taught to Danielle by her father and me, as both he and I struggle to bring in our own incomes and support our daughter's wishes/hopes at the same time.

Sharon, as an older adult, could experience, with the possibility of a budget cut by the Montana legislature regarding Medicaid funding for the Pace Program, what Danielle is experiencing. Sharon can no longer be independent and needs support. Without the necessary funding support she would no longer be able to live in the wonderful, nurturing environment that Pace has provided.

As with my daughter, to place Sharon in a nursing home not only would cost the government about 4 times as much as is currently being spent on her care (according to some estimates), but would be a denial of her basic human right to live in her community, under the Olmstead Act. Please, remember, respect, and support those who are not able to speak for themselves. Someday we may all walk in similar shoes as Sharon and Danielle. Thank you.

Stephanie James
110 Buttermilk Lane
Bailey, CO 80421
303-816-0264

January 14, 2011

Senator Dave Lewis
Montana Senate
PO Box 200500
Helena MT 59620-0500

Dear Senator Lewis:

Thank you for taking the time to read my letter and serve the State of Montana. I am writing to ask you to support and fund the PACE program as a senior advocate in our community who has seen the positive impact of this program.

As a certified member of SHIP (State Health Insurance Assistance Program), I frequently refer clients to assistance programs such as Extra Help through Social Security, Big Sky Rx and PACE. For those who qualify, PACE has provided valuable support so that PACE participants can continue to live safely at home.

Please support PACE and remember this is a proven approach that is good for our Montana elderly population!

Thank you for listening and respecting the wishes of our elderly population who wish to remain in their homes as long as possible.

Sincerely,

Bobbi Roberts, Coordinator
Senior Life Partners
Billings Clinic
PO Box 37000
Billings MT 59101
(406) 657-4400

January 13, 2011

Dear Member of the Joint Appropriations Committee on Health and Human Services:

I am writing to you as a caregiver of people who participate in PACE. I know you are grappling with many tough public health funding issues and I appreciate your public service.

I work at the Billings Clinic, which operates the PACE program. PACE programs function as a fully accountable care organization. They are responsible for the quality and cost of **ALL** care provided both directly and through contracted providers. Monthly capitated payments from Medicare and Medicaid are pooled and care is provided following a comprehensive assessment of the participant's needs. PACE's inclusive capitated single payment for all necessary care provides strong incentives to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and nursing home care.

Billings Clinic approached the state DPHHS in 2007 and encouraged them to offer this managed care option to the dual-eligible population in our state. After much investment, time and money, and learning how to deliver health care to a complex, high cost population on a fixed budget, we are faced with our Medicaid funding being eliminated, should the Governor's budget be enacted by the Legislature. The program will be forced to close. Billings Clinic believes this will be a short-sighted decision.

I have directly seen the positive personal impact of this program -- but believe there are financial benefits to this program as well. Please support PACE.

Sincerely,

Deborah Thompson, RN

PACE Staff - General

January 12, 2011

Representative Don Roberts
Senator Dave Lewis
Representative Tony Belcourt
Representative Mary Caferro
Representative John Esp
Senator Jason Priest
Representative Trudy Schmidt

Honorable Representatives and Senators:

I am writing to you to urge you to restore funding for the PACE program. I have been privileged to be affiliated with the Billings PACE program as the social worker since it's opening in October of 2008, and I have witnessed the good it has done in the lives of the PACE participants. I have watched frail isolated elders thrive under the coordinated care they receive from PACE as PACE offers a level of care coordination not available in other programs. We serve all the needs of our participants rather than just one or two.

PACE is currently serving 52 elders in Billings, and if this program is forced to close, many of them will fall between the cracks again. I am especially concerned for several of our participants who have no family support. Bob, for example, was referred to us by a Billings Southside church when he requested food from them. Bob is a Korean War veteran who also has a plate in his upper leg as the result of an accident. When we first met Bob, it was obvious that he suffered from dementia. His girlfriend had died, and he was isolated socially. He had multiple medical and social needs to be addressed. Bob knew enough to seek help, but help usually came in the form of a band-aid for one isolated problem. After enrollment, the PACE team approach began to work its magic. Bob's overall physical condition has improved due to more medical attention. He attends our Day Center several days a weeks which provides him with a social outlet, and in home services assist him with grooming, housekeeping, and the preparation of meals. Food stamps were obtained for Bob which help keep his cupboards full. Unfortunately, my efforts have not resulted in finding any family members. PACE is able to address the whole person, and Bob is a good example of how overall quality of life is improved with this approach. A second example is Mary. Mary is one of our younger elders as she entered the program at age 65. Mary is a widow with no children, and when her husband died she had to be hospitalized. She was diagnosed as bi-polar and was receiving mental health services when she came to the PACE program. however, she had ceased taking her medications and was suffering a psychotic break. She was referred to us by a paid caregiver who was concerned about how isolated Mary was and felt Mary needed more assistance. Again, the PACE team approach began to work with Mary. More assistance was put into the home, Mary became a regular at our Day Center, and her medical care was increased and better coordinated. If PACE closes, where will Bob and Mary receive such coordinated care?

Thank you.

Sincerely,

Diann Spear, LCSW

January 12, 2011

Dear Members of the Joint Appropriations Committee on HHS,

Chair: Rep. Don Roberts
Vice Chair: Sen. Dave Lewis
Rep. Tony Belcourt
Rep. Tom Burnett
Sen. Mary Caferro
Rep. John Esp
Sen. Jason Priest
Rep. Trudi Schmidt:

Thank you for taking the time to read my letter and for your service to the State of Montana.

I am writing to ask you to support and fund the PACE program. I know the positive impact of this program, as one of my first cousins, Clark and his wife, Sharon who suffers from a debilitating form of dementia, are directly benefiting from the services of PACE. Clark has mentioned several times that PACE has given him his life back, as care for Sharon is not his exclusively. A certain sense of normalcy has been restored to their lives. The care Sharon receives through PACE is vital to her life and thus, Clark's life, as well.

Those who most need our help must not be forgotten.

Please support PACE and remember this is a proven approach that is good for Montana's elderly population!

Thank you for listening.

Sincerely,

Gretchen Wrede
3066 S. Osceola St.
Denver, CO 80236
303-922-7601

cc: Billings Clinic PACE
Attn: Anne Gonzalez

January 7, 2011

Dear Member of the Joint Appropriations Committee on Health and Human Services:

Thank you for serving at the Montana Legislature. I know you give up your time with family and friends for public service and I appreciate it.

I want to tell you why PACE helped me, but first I want to share with you a story about another participant -- Sharon. Sharon was enrolled in PACE in February of 2009 after her husband heard about the program. Sharon is a 61-year-old female who was unfortunately diagnosed with early onset Alzheimer's dementia about six years ago.. Her husband quit his job so he could be her caregiver as he no longer felt comfortable leaving her alone. One of the reasons he wanted Sharon to enroll in the program was so that he could return to work and she would receive supervision while he was there.

After enrollment, we provided in-home care twice a day five days a week and she came to the Day Center five days a week. Being a very social individual, Sharon thrived in the Day Center environment. She was able to make new friends and quickly won over the hearts of the Day Center staff. Her husband was able to return to work and many of his care-giving tasks were relieved so he was able to focus on being a husband when he was with Sharon instead of a caregiver.

Sharon's dementia has continued to progress. Her husband recently decided that her care was more than he could handle. PACE was able to find a room for her at a personal care home. The intimate social environment of the personal care home is well suited for her personality. She continues to come into the Day Center several days a week. Her husband is very grateful for the care she has received through the PACE program; care which has enabled him to return to work. He feels that without the PACE program, she would have been placed in a nursing home a long time ago.

Please allow me to introduce myself to you, my name is Clark Swan. I am Sharon's husband and we are deeply grateful for Pace and her caregivers. This program has been a Godsend and a lifesaver, in more ways than we can ever imagine. A short anecdote, to illustrate her progression, she has attached herself to a resident in her personal care home, a gentleman in a wheelchair and on oxygen—she thinks he is me!

Thank you for supporting PACE.

Sincerely,
Clark E. Swan

PACE Participant/Family Member

From: J-P [jackandpaulette@live.com]
Sent: Monday, January 10, 2011 12:24 PM
To: Barry & Dayana ; Bruce Abbott ; Craig & Cindy Nickel; Daron Olson ; Elaine Johnson ; Gary Rylander ; Hanna Olson ; Jennifer & Jordan Romero ; Jill Foran; John & Joyce Olson ; Karen Olson ; Kevin Gerrells; Kristie Olson ; Linda Frey; Michelle Olson ; Mom & Dad Olson ; Patrica Ball ; Paul Roberts; Peggy Canan; Frank Park
Cc: Gonzalez Lewis, Anne; DeLeonardo, Paulette
Subject: I need your help to support PACE

Hello All:

The Montana Health and Human Services Joint Appropriations Subcommittee of the Legislature will be hearing the DPHHS/Senior and Long Term Care budget recommendations on Monday January 24. DPHHS has recommended the elimination of the PACE program in Montana.

On the Morning of January 24, the committee will accept testimony both in favor of maintaining the PACE program and proponents of its elimination.

As part of our legislative strategy, Billings Clinic PACE is promoting a letter writing campaign which we hope will show the committee that PACE in Montana has broad based support. We hope that the amount of support will be compelling and cause the committee to consider maintaining PACE funding in the DPHHS budget.

Please support PACE in Montana by writing a letter of support. I am also urging each one of you to reach out to those you know who would be willing to send letters in support of PACE to the HHS subcommittee members.

Attached is a "draft" letter. The letter provides some language guidance and themes that may be used. Supporters can "flesh out" the letters with their own thoughts and/or experience.

Since the hearing is on Monday January 24, we would like the members of the committee to receive the letters not later than Friday January 21. Letters should be sent to each of the committee members.

We want to take copies of all the letters to the hearing and present them to the committee as well as have letters sent to each individual member. If possible, please copy letters (electronic is best) to this email address: (AGonzalezLewis@billingsclinic.org) or hard copy to the PACE center:

Billings Clinic PACE
Attn: Anne Gonzalez
3155 Avenue C
Billings, MT 59102

Here is a list of Health and Human Services Committee Members:
Chair: Rep. Don Roberts (R-Billings) email address not provided
Vice Chair: Sen. Dave Lewis (R-Helena) davelewisd@aol.com
Rep. Tony Belcourt (D-Box Elder) tbelcourt@hotmail.com
Rep. Tom Burnett (R-Bozeman) burnett.tom@gmail.com
Sen. Mary Caferro (D-Helena) marycaferro@gmail.com
Rep. John Esp (R-Big Timber) jesp@mtintouch.net
Sen. Jason Priest (R-Red Lodge) jason@priest2010.com
Rep. Trudi Schmidt (D-Great Falls) trudischmidt@q.com
Staff: Lois Steinbeck, 406-444-5391 lsteinbeck@mt.gov
Marilyn Daumiller, 406-444- 5386 mdaumiller@mt.gov
Kris Wilkinson, 406-444 -2722 kwilkinson@mt.gov
Secretary: Miranda Keaster, 406-444-7353

Send email and/or address letters to:
Senator XXXX
Montana Senate
PO Box 200500
Helena, MT 59620-0500
or
Rep. XXXX
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

Our goal is to FLOOD the committee with letters of support. Please assist us with this effort.

Thank you for your support!
Paulette

This letter was originated from Anne Gonzalez, I just tweaked it for all my favorite Billings email friends! I have worked for PACE even before it opened in

2008, it is a part of Billings Clinic. For those of you who don't know much about PACE, here is the lowdown.

The *Program of All-Inclusive Care for the Elderly* (PACE) coordinates, provides and supervises all the home and health care needs of your loved one. PACE allows participants to remain safe and comfortable in their own home and community - and out of a nursing home. The care includes:

- Medical care
- Personal care
- Rehabilitation
- Social interaction
- Medications

PACE is designed to better coordinate services; simplify payment; and gain control of health care costs. Each person is cared for by a team of physicians, nurses, social workers, therapists and other providers who work together to ensure that care is delivered based on the unique needs of the participant. Most care is provided in the participant's home or our adult day health center and primary care clinic.

To be eligible to participate, all 4 requirements must be filled?

- Those 55 years of age or older
- Residents of Yellowstone County, Montana
- Individuals eligible to receive nursing home level of care
- Individuals able to live safely at home with assistance

PACE is primarily funded by Medicare and Medicaid. Individuals who are not receiving full Medicare or Medicaid support can still participate by paying a fixed monthly amount.

Once enrolled in PACE, the amount paid each month will not change no matter what care and services are needed. The program provides all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically-necessary care and services not covered by Medicare and Medicaid.

In PACE there is never a co-pay, deductible or coverage gap so the care, services and medications needed can be accessed at any time. Because PACE provides and is responsible for all care, the participant may be held financially responsible for any care received outside the program that is not approved by the PACE interdisciplinary team.

January 19, 2011

Dear Member of the Joint Appropriations Committee on Health and Human Services:

I am writing to you as a caregiver of people who participate in PACE. I know you are grappling with many tough public health funding issues and I appreciate your public service.

I am employed by Billings Clinic, which operates the PACE program, and I am the physical therapist providing care to the participants of the PACE program. PACE programs function as a fully accountable care organization. They are responsible for the quality and cost of **ALL** care provided both directly and through contracted providers. Monthly capitated payments from Medicare and Medicaid are pooled and care is provided following a comprehensive assessment of the participant's needs. PACE's inclusive capitated single payment for all necessary care provides strong incentives to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and nursing home care. As the physical therapist, I am responsible for completing assessments, providing therapy treatments, and determining equipment needs, all to ensure our participants remain safe with their functional mobility to remain in their home environment. I have been involved with the PACE program for over two years and have seen the many benefits of this program for our participants. They are able to remain as independent as possible in their home or assisted living with decreased burden of care on family members. Many of our participants have no family to help them in this stage of their life, and PACE has become their family. The smiles and laughs seen and heard in the day center are evidence of this.

Billings Clinic approached the state DPHHS in 2007 and encouraged them to offer this managed care option to the dual-eligible population in our state. After much investment, time and money, and learning how to deliver health care to a complex, high cost population on a fixed budget, we are faced with our Medicaid funding being eliminated, should the Governor's budget be enacted by the Legislature. The program will be forced to close. Billings Clinic believes this will be a short-sighted decision. It is my professional opinion that if many of our participants no longer had the services PACE provides, they would need to be placed in a nursing home for their safety. This would cost the state money as well for Medicaid payments to nursing homes.

I have directly seen the positive personal impact of this program -- but believe there are financial benefits to this program as well. Please support PACE.

Sincerely,

Amanda Langve
Physical Therapist
Billings Clinic PACE